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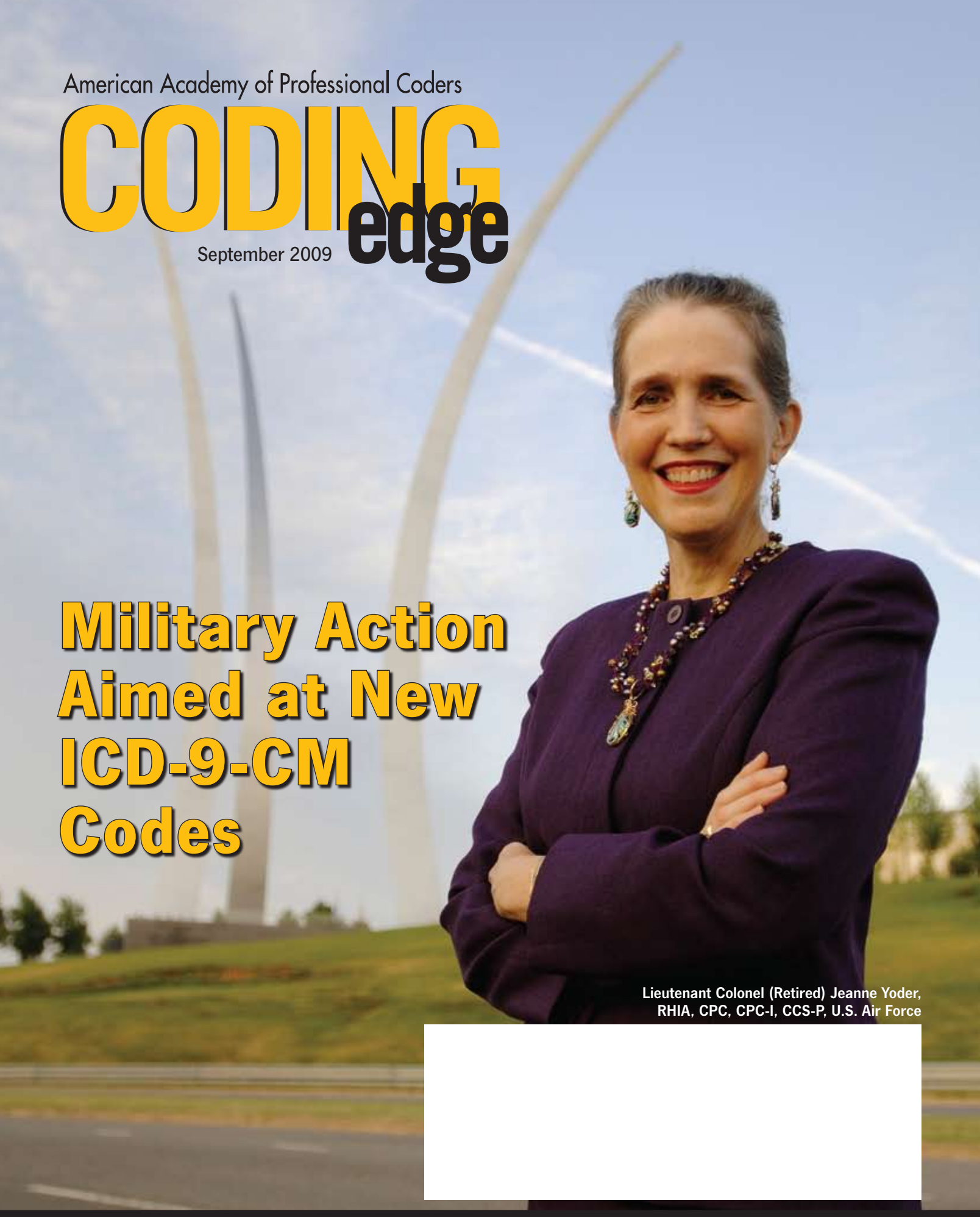
Military Action Aimed at New ICD-9-CM Codes



Lieutenant Colonel (Retired) Jeanne Yoder, RHIA, CPC, CPC-I, CCS-P, U.S. Air Force

Plus: Radiation Oncology • NPP Billing • Perfusion Studies • Carpal Tunnel • H1N1 Codes

The *"it"* in HIT

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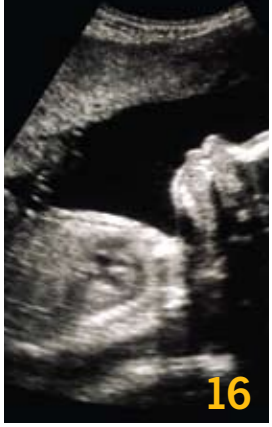

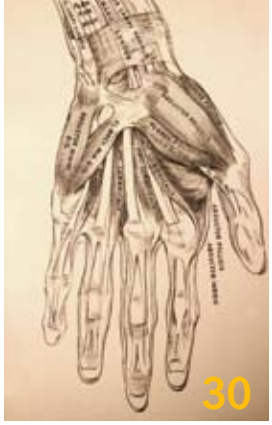

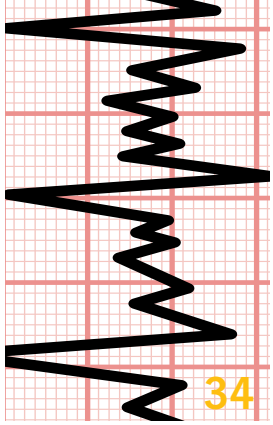

[contents]

Features

On the Cover: *Lieutenant Colonel (retired) U.S. Air Force, Jeanne Yoder, RHIA, CPC, CPC-I, CCS-P, now with TRICARE Management Activity, stands in front of the Air Force Memorial in Washington, D.C. Cover photo by Mark Molesky (www.moleskyphoto.com).*

In Every Issue

Education

People

Coming Up

Serving 80,500 Members – Including You

Targeting the AAPC Audience

The membership of AAPC, and subsequently the readership of *Coding Edge*, is quite varied. To ensure we are providing education to each segment of our audience, in every issue we will publish at least one article on each of three levels: apprentice, professional and expert. The articles will be identified with a small bar denoting knowledge level:

APPRENTICE	Beginning coding with common technologies, basic anatomy and physiology, and using standard code guidelines and regulations.
PROFESSIONAL	More sophisticated issues including code sequencing, modifier use, and new technologies.
EXPERT	Advanced anatomy and physiology, procedures and disorders for which codes or official rules do not exist, appeals, and payer specific variables.

AAPC Code of Ethics

Members of the American Academy of Professional Coders (AAPC) shall be dedicated to providing the highest standard of professional coding and billing services to employers, clients, and patients. Professional and personal behavior of AAPC members must be exemplary.

- AAPC members shall maintain the highest standard of personal and professional conduct. Members shall respect the rights of patients, clients, employers, and all other colleagues.
- Members shall use only legal and ethical means in all professional dealings, and shall refuse to cooperate with, or condone by silence, the actions of those who engage in fraudulent, deceptive, or illegal acts.
- Members shall respect and adhere to the laws and regulations of the land, and uphold the mission statement of the AAPC.
- Members shall pursue excellence through continuing education in all areas applicable to their profession.
- Members shall strive to maintain and enhance the dignity, status, competence, and standards of coding for professional services.
- Members shall not exploit professional relationships with patients, employees, clients, or employers for personal gain.

This code of ethical standards for members of the AAPC strives to promote and maintain the highest standard of professional service and conduct among its members. Adherence to these standards assures public confidence in the integrity and service of professional coders who are members of the AAPC.

Failure to adhere to these standards, as determined by AAPC, will result in the loss of credentials and membership with the American Academy of Professional Coders.

American Academy of Professional Coders

American Academy of Professional Coders
CODING edge
September 2009

Address all inquires, contributions and change of address notices to:

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PO Box 704004
Salt Lake City, UT 84170
(800) 626-CODE (2633)

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Only a Phone Call Away

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Cali Farmer	Member representative	Ext. 197
Chris Christiansen	Director of IT	Ext. 118
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Danielle (Dani) Montgomery	Director of member services	Ext. 111
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Sheri Bernard, CPC, CPC-H, CPC-P	Vice President, clinical content	Ext. 168
Wendy Willes	Examinations	Ext. 108

It's a good idea to periodically update your list of important contacts at the AAPC. Knowing an AAPC team member's occupation and how to get hold of the person can help you answer membership, education, or coding questions in a timely manner. We've added a few people recently, so consider photo copying this page to keep for reference.

The main phone line to the AAPC is **800-626-CODE (2633)**. From there, you can input the extension number of the person you wish to contact.

Stephanie Jones, CPC, CEMC, is now the executive director of the American Society of Health Information Managers (ASHIM), a new organization credentialing people in both health care knowledge and IT skills.

Members are encouraged to contact us whenever they are in need of assistance; we are just a phone call (or email) away. Our general email address is **info@aapc.com**.

ICD-10-CM Implementation Training

The AAPC is fortunate to have the preeminent expert on ICD-10, Deborah Grider, leading our implementation development and training efforts. We are confident she will provide the best knowledge and training there is.

In July, the AAPC launched our ICD-10-CM implementation training with a series of free webinars—one for providers and one for payers. If you were unable to listen live, they are available for download from our Web site (www.aapc.com). These are an invaluable resource of information to help you get started on the ICD-10 transition. CEUs from these free webinars are available for a small fee ($19.95 and $29.95).

The AAPC offers implementation training in a wide variety of formats so members and their employers can train in the delivery mechanism they most desire: custom onsite training for both provider practices and small payers or payer facilities, e-learn training, live workshops and webinars, and regional and national conferences. Implementation training begins in early 2010 with custom onsite training and webinars to follow within a few months. You may contact us now for more information on the custom onsite training pricing and scheduling. We will have up to 32 well trained implementation experts available to assist you.

Remember: Use the "ICD-10 Preparation" tracking tool in the upper, right-hand corner of your Member Area home page to guide you and your employer on ICD-10-CM tasks and schedules. CE

Sincerely,

Reed E. Pew
CEO and President

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Regional Conferences Offer Oases of Coding Value

Regional conferences provide an opportunity to network with peers and make new friends while keeping abreast on coding. This year, the AAPC has two regional conferences scheduled for fall: Ko Olina, Oahu, Hawaii, Sept. 10-12; and Virginia Beach, Norfolk Va., Oct. 8-10. The Hawaiian regional conference at JW Marriott Ihilani Resort and Spa is located in a picturesque setting overlooking the Pacific Ocean. The tropical breezes and relaxed surroundings come at no extra cost. If your physician is reluctant to send you to Hawaii for a coding conference, suggest he or she go with you. The itinerary features excellent classes geared especially for physicians. If you prefer the East Coast, then you might consider the Virginia Beach conference. I look forward to attending this conference. I've heard the hotel has a breath-taking Atlantic Ocean view, and there are plenty of local attractions. Although these things are not why we attend a regional meeting, the serene settings instill mental clarity and add to the overall conference experience.

Money-saving Education

The economy has tightened everyone's budget but the networking and educational benefits of attending conference are priceless. The great thing about regional conferences is that they move around the country, so there may be one coming to a town near you. To review all of the conferences offered by the AAPC, go to the AAPC Web site at www.aapc.com. Regional conferences also have smaller attendance rates and lower registration fees, yet still maintain the same educational and networking value as a national conference. Clearly, regional conferences offer a convenient way to obtain CEUs, while suiting your budget needs.

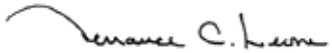
To get even more bang for your buck, consider the following:

- Turn the conference into a family vacation to mix business with pleasure.
- Rather than fly to the conference, drive, car pool, or rent a bus for a larger group of attendees.
- Share rooms with other members.

Stop and Say "Hi"

During my tenure as your NAB president, I'd like to meet each one of you. Please stop me at any regional or national conference, introduce yourself, and tell me where you are from. I enjoy meeting the members that I represent. That way, I can put a name with the face of each of our 80,500 members.

Sincerely,



Terrance C. Leone,
CPC, CPC-P, CPC-I, CIRCC
President, National Advisory Board

Please send your letters to the editor to: letterstotheeditor@aapc.com.

Letters to the Editor

Remote Coding is a Balancing Act

I received my July 2009 *Coding Edge* magazine and was happy to see the article "Coding from Home." I am a remote coder living in Tennessee working for a company in California. I love my job and the flexibility it offers my family life. My manager is awesome, and my job allows me to work and still attend functions at my son's school, finish my college degree, and have free time to visit and travel with my family. I have less stress, no commute, and fewer expenses—such as gas, lunch, and clothing.

The best thing for me is the time factor. My former commute was 90 minutes each way. Now, I walk to work—from my bedroom to my office, which is a converted spare bedroom.

It takes a special person to be able to work from home with the distractions that may come up, such as holidays or days when your children or spouse is home from school or work. It's important to have a schedule and to be able to focus. Bottom line: Remote coding is a delicate balance.

Speaking personally, working remotely allows me to be the three things I love most: a wife, mother, and CODER!

Sincerely,

Jennifer Bowyer, CPC, CEMC, lead coder/auditor, Peak Health Solutions

Thanks to Terry Leone for the article "The Pros and Cons of Working from Home" [July *Coding Edge*]. Although the idea of working from home is a common sought out opportunity for many coding professionals, I agree with Terry in that it requires a much disciplined individual to maintain productive work habits when not in the office.

The hospital I currently work for allows coders to work from home one day per week. In my situation, I have a 70-mile commute per day, so it assists me in cutting down my expenses. I truly appreciate this privilege, as I see many of my peers working for facilities that do not have remote coding.

It requires much work on the part of the coding supervisor and the department director to monitor their coders' productivity; and it is certainly a risk and potentially harmful to the organization if not monitored properly.

Thanks,

Susan Kelly, CPC, coding technician, Gaylord Hospital

Take "Test Yourself" Anywhere

It was much more convenient to have the "Test Yourself" page inside *Coding Edge* magazine, rather than online only. That way, you had more time to peruse the articles at your convenience (whether or not a computer was nearby), circle correct answers, and then go online to submit them. Is there any way we could bring it back to the magazine?

Thanks,

Judy A. Weber, CPC, CCS-P

I just wanted to give feedback on the test yourself online. I did not think I would like it, but it is much easier to keep track of the CEUs this way. Great idea.

Carrie Bailis, CPC

If you want a paper copy on which to make notes while reading the magazine, just log onto the member page and click on the *Coding Edge* cover, located in the lower-right corner, or follow this link: www.aapc.com/MemberArea/resources/coding-edge/index.aspx.

Once you're at the Coding Edge Archive page, click on the Test Yourself link for the issue you wish to test. Right-click (Windows) or [Control]-click (Mac) on the test and select Print from the dropdown menu. Set the printing options in the Print dialog box as you wish, and then click Print. This will give you a printed page on which to write notes and answers. Just remember to go back online to enter your answers and receive your CEUs!

Coding Edge

Payers May Differ on V Code Placement

In the May 2009 issue, the article "Don't Fall into the V-code Rut" (pages 12-14) states in the last paragraph V76.51 *Special screening for malignant neoplasms of the colon* should remain as the first-listed diagnosis even if a polyp is found and removed. Although this is true as far as ICD-9 coding guidance is concerned, such advice may be confusing to some facility readers because many fiscal intermediaries (FI) have local coverage determinations (LCDs) requiring hospitals to follow different diagnosis reporting and sequencing requirements for colonoscopy procedures.

LCDs apply only to Medicare patients; however, given the great number of Medicare patients using their screening colonoscopy benefit, it is an important caveat that although hospitals outpatient departments should follow ICD-9-CM coding guidance, LCDs issued by their FI will take precedence.

Thanks,

Melissa Fincham, CPC, CPC-H
senior consultant, Health Revenue Assurance Associates

Many thanks for the reminder. Indeed, the *ICD-9-CM Official Guidelines for Coding and Reporting* (Section I.C.18.d.5) specify, "A screening code may be a first listed code if the reason for the visit is specifically the screening exam ... Should a condition be discovered during the screening then the code for the condition may be assigned as an additional diagnosis." Under these directions, the screening code remains primary even if, in the case of a colonoscopy, a polyp is found. As you note, however, payers may provide contrary instructions. As long as these instructions appear in writing (for instance, within an LCD or as part of your contract with the payer), be sure to follow them.

Coding Edge

ICD-9-CM Official Guidelines are Part of the Code Set

Regarding the inclusion of the *Official ICD-9-CM Guidelines for Coding and Reporting* in the ICD-9-CM code set under Health Insurance Portability and Accountability Act (HIPAA), as relates to Michael Miscoe's article in the June 2009 issue ("Identify Binding Rules for Defensible Coding," pages 14-16), Miscoe wrote:

"The first rule in our criteria hierarchy, regardless of the case, is the HIPAA code set rule identified earlier. When applying this rule, remember that your code set is nothing more than the CPT®, HCPCS Level II, and ICD-9-CM codes with their descriptions. The instructions contained within these manuals detailing the publishers' guidance for how to use the codes are not part of the code set. As a result, these instructions are not controlling (binding) unless the carrier formally adopts these instructions in a binding policy."

In fact, the wording under the law, 45 C.F.R. 162.1002(a) and 162.1002(b), seems to indicate that the ICD-9-CM *Official Guidelines for Coding and Reporting* are part of the ICD-9-CM code set adopted under HIPAA. Further, the introduction to the ICD-9-CM *Official Guidelines for Coding and Reporting* specifies, "Adherence to these guidelines when assigning ICD-9-CM diagnosis and procedure codes is required under the Health Insurance Portability and Accountability Act (HIPAA)."

The corrected paragraph would read:

"The code set for physician services is nothing more than the CPT® and HCPCS Level II codes and descriptions. The instructions contained within these manuals detailing the publishers' guidance for how to use the codes are not part of the code set. As a result, these instructions are not controlling (binding) unless the carrier formally adopts these instructions in a binding policy. After isolating your codes and descriptions, coders must identify and list all possible code choices that fairly and accurately describe the service performed. Refining this list to a single code requires more analysis. Note: The same is not true for ICD-9-CM, where the regulation expressly incorporates 'The Official ICD-9-CM Guidelines for Coding and Reporting.'"

Resource tip: The ICD-9-CM *Official Guidelines for Coding and Reporting* may be found at: www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/icdguide08.pdf.

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KUDOS!

Here's Lookin' at You, Kid

We at *Coding Edge* like to think the magazine has a broad appeal to coders of all ages, but we weren't expecting this: Derek Leone, seven-month-old grandson of National Advisory Board President **Terry Leone**, shows great interest in April's issue. Terry tells us that he received this picture on his phone after being inducted as NAB president at the April ceremony during the AAPC's National Conference in Las Vegas. It meant a lot, he told us, and we can see why. Kudos to Derek—a future coder.

Coders Honored as National Small Business Champions

Founders of a program that helps train and employ rural coders were honored in May by President Barack Obama and the Small Business Administration (SBA). **Nancy Reading, RN, BS, CPC, CPC-I; Jenny Cox, MA, CPC; Barbara McGann, CPC; and Kris Simeona, CPC** were chosen from hundreds of national applicants and honored with nine other national champions at a luncheon in Washington, D.C. The coders were recognized for partnering with a local college to train coders and establishing a medical coding and reimbursement company employing its graduates in a particularly poor, remote part of the Southwest's Four Corners Region.

After being honored locally and nationally, attending SBA workshops, and rubbing shoulders with colleagues and the powerful, the question remained: What was it like to meet the president of the United States? Reading's response: It was "Soooooo cool!"

Kentucky Coder a Knowledgeable OASIS

Congratulations to **Anthony W. Bush, CPC, CCP, CCP-P, COS-C**, manager of health information management and case management review, Nurses Registry and Home Health. Anthony recently passed the Certificate for Outcome and Assessment Information Set (OASIS) Specialist-Clinical (COS-C) offered by the OASIS Certificate and Competency Board, Inc. (OCCB). This certification illustrates proficiency and competence in data accuracy of OASIS clinical documentation for home care professionals. Familiar with both home health and payer programs, Anthony holds a Medical Coding and Billing certificate from the National College of Business and Technology in Lexington, Ky. and has enrolled in the Health Information Technology (HIT) program at Fisher College.

Coding Excellence Spreads Worldwide

Congratulations to the new chapters popping up in the United States, as well as internationally. It takes dedicated members to start a local chapter to provide continuing education for other members. Many thanks go out to the new chapters who pursue and provide the highest coding standards.

If you haven't had a local chapter near you in the past, maybe there's one now. New chapters include:

Albany, Ga. — Bemidji, Minn. — Bloomington, Ill. — Brandon, Fla. — Bucyrus, Ohio — Concord, N.C.— Danville, Ky. — Great Falls, Mont. — Guam —Helena, Mont. — Hibbing, Minn. — Hines, Ill. — Jacksonville, N.C. — Klamath Falls, Ore. — Locust Grove, Ga. — Panama City, Fla. — Woodbridge, Va.

If you or a colleague deserve kudos, please email kudos@aapc.com.

coding news

Medicare Launches Supplier Competitive Bidding Effort

The 60-day supplier bidding period will begin in late October for the Medicare Competitive Bidding Program's Round One Rebid for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). To help suppliers prepare for bidding in the nine competitive bidding areas, the Centers for Medicare & Medicaid Services (CMS) is leading a supplier outreach and education effort.

The competitive bidding program and Medicare's quality standard requirements will help beneficiaries who need medical equipment and supplies to maintain high quality items and services. "Competitive bidding is an essential tool to help Medicare pay appropriately for health care—important not only to maintain Medicare beneficiaries' access to high quality medical items and services, but also to lower the cost of medical care for all," said Jonathan Blum, director of CMS' Center for Medicare Management. "We are committed to ensuring that suppliers have up-to-date information and guidance so they may submit bids to furnish high quality, affordable medical items and services under the competitive bidding program."

The Round One Rebid is in the areas:

- Cincinnati, Middletown (Ohio, Kentucky, and Indiana)
- Cleveland, Elyria, Mentor (Ohio)
- Charlotte, Gastonia, Concord (North Carolina and South Carolina)
- Dallas, Fort Worth, Arlington (Texas)
- Kansas City (Missouri and Kansas)
- Miami, Fort Lauderdale, Miami Beach (Florida)
- Orlando (Florida)
- Pittsburgh (Pennsylvania)
- Riverside, San Bernardino, Ontario (California)

The Round One Rebid will include the items:

- Oxygen and oxygen equipment
- Standard power wheelchairs, scooters, and related accessories
- Complex rehabilitative power wheelchairs and related accessories (Group 2 only)
- Mail-order replacement diabetic supplies
- Enteral nutrients, equipment and supplies
- Continuous positive airway pressure (CPAP) machines, respiratory assist devices (RADs), and related supplies and accessories
- Hospital beds and related accessories
- Walkers and related accessories
- Support surfaces (Group 2 mattresses and overlays in Miami only)

This doesn't affect Medicare DMEPOS benefit until the program begins again in 2011. Until then, Medicare beneficiaries can get their Medicare-covered equipment and supplies from any Medicare-approved supplier.

CMS launched an extensive education and outreach effort on Aug. 3 to guide suppliers through the competitive bidding process. For additional information about the Medicare DMEPOS Competitive Bidding Program, visit: www.cms.hhs.gov/DMEPOSCompetitiveBid/. For bidder assistance, go to: www.dmecompetitivebid.com or call the toll-free help line (1-877-577-5331).

FTC Buys More ID Theft Time

For those who weren't ready for Identity Theft Red Flags Rule enforcement on May 1, nor on Aug. 1, you're in luck. Just days away from the Aug. 1 implementation deadline, the Federal Trade Commission (FTC) announced July 29 it will further delay the Rule's effective date. Creditors and financial institutions now have until Nov. 1 to develop and implement a written Identity Theft Prevention Program.

The FTC's Red Flags Web site (www.ftc.gov/redflagsrule) offers resources to help entities determine if they are covered and how to comply with the Rule. It includes an online compliance template enabling companies to design their own Identity Theft Prevention Program, as well as articles directed to specific businesses and industries, guidance manuals, and Frequently Asked Questions (FAQ) to help companies navigate the Rule.

For more on how the rule pertains to medical practices, read *EdgeBlast* #130 (www.aapc.com/e-blast/issue130.html), and/or "Red Flags Rule Protects Patients" on page 18 of February's *Coding Edge*.

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Hot New Topic!

Back to Basics: Everything You Wanted to Know About Coding But Were Afraid to Ask

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Radiation Oncology Presents Complex Coding Challenges

Check bundling and documentation issues before coding claims.

By Robert H. Ekvall, PhD, CPC-H, CPC, CCS

Radiation oncology presents a unique challenge in the arena of hospital outpatient coding. Unlike other medical disciplines, the radiation oncologist and the hospital or freestanding center can bill for the preparation work of the radiation oncologists, physicists, and dosimetrists in developing the proper course of treatment.

Be Clear on Bundling Guidelines

Be aware of the different charges that are bundled. When the radiation oncologist treats the patient with intensity modulated radiation therapy (IMRT), bundling awareness is key. The national Correct Coding Initiative (CCI) edits explain which charges are bundled into the IMRT plan (77301 *Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications*) on the same service date. Knowing which charges are bundled or included in the IMRT plan, no matter what the service date is, can be tricky.

CPT® doesn't provide bundling clues like "separate procedure" in radiology as it does with the surgical codes. Special dosimetry (77331 *Special dosimetry (eg, TLD, microdosimetry) (specify), only when prescribed by the treating physician*) is a procedure considered to be "included" or always bundled with IMRT because it is considered part of the IMRT planning process.

The same holds true for special physics consult 77370 *Special medical radiation physics consultation*, unless there are extenuating or special circumstances where the radiation oncologist needs special advice from the physicist above and beyond the IMRT planning process. Two examples include: (1) a patient who has a pacemaker; or (2) radiation therapy for an area previously treated with radiation.

Use Special Treatment Code Only When Warranted

Special treatment procedure 77470 *Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral, endocavitary or intraoperative cone irradiation)* can pose a challenge. Like modifier 22 *Unusual procedural services*, this is a code often abused or misused—leading to scrutiny by the Recovery Audit Contractors (RACs) or Medicare auditors. A radiation oncologist should report 77470 when she believes the clinical treatment planning process required extra cognitive processing (additional work) above and beyond the normal treatment plan because of special circumstances. Some examples include:

- Concurrent chemo/radiation therapy
- Hyperfractionation (two or more treatments performed daily)
- Brachytherapy
- Retreatment of the same anatomic area with radiation
- Artificial implants

Note that code 77470 can only be billed once per course of treatment.

Some may feel the amount of work going into an IMRT plan (77301) or a 3D simulation plan (77295 *Therapeutic radiology simulation-aided field setting; 3-dimensional*) should qualify automatically for a special treatment procedure. The American Society for Therapeutic Radiation Oncology (ASTRO) and the American College of Radiology (ACR) wrote a radiation oncologist guideline book to use with coding staff. On page 77 of *ASTRO/ACR Guide to Radiation Oncology Coding 2007*, the following opinion or advice was given in response to a coding question:

"Contouring for 3D-CRT® and IMRT are part of the physician work of CPT® code 77295 … and 77301 … In radiotherapy, situations arise where additional physician and facility work is involved in treating a patient, and then it is appropriate to report code 77470."

The ASTRO/ACR Guide listed examples of certain situations that might warrant CPT® 77470, but they concluded their opinion with the following advice: "Hence, there is no case where it is routinely used, and therefore

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the physician should decide to report CPT® 77470 on a case-by-case basis and document the work effort involved."

The doctor should document the medical reasons why a patient qualifies for 77470 reimbursement, and be able to defend his or her rationale.

Cloned Documentation Falls Short of 77470

I have seen firsthand at radiation oncology coding conventions less desirable documentation examples where 77470 was charged. One example is the use of nonpatient-specific, cloned notes. Another example is using checklists where the doctor checks off boxes for the reason he wants 77470 charged, with no specific details to the extra work or cognitive processing.

To protect doctors and hospitals from scrutiny by RACs, make sure documentation is patient-specific and clearly describes the extra cognitive processing involved in creating the patient's treatment plan. Avoid the temptation of inferring from the doctor that a 77470 should be charged because the documentation shows the patient is receiving concurrent chemotherapy with radiation therapy. The doctor needs to describe the extra work involved in communicating and collaborating with the medical oncologist.

Keep Abreast on Guidelines

Read, study, and abide by the *Federal Register*, the Centers for Medicare & Medicaid Services (CMS) guidelines, payer guidelines, and other authoritative resources as they relate to radiation oncology coding. If you're still confused after reading the authoritative guidelines, there are other resources to find professional advice or opinions. To help deal with complex coding challenges, radiation oncology coders and staff should work together and attend radiation oncology coding conventions or take online courses.

Once a year, the Southeastern Association for Therapeutic Radiation Oncology (SATRO) brings together professional consultants/auditors to debate and educate managers, doctors, coders, auditors, and compliance officers about radiation oncology coding challenges. Other great resources are the American Society for Therapeutic Radiation Oncology (www.astro.org) and the *CPT® Assistant* archives.

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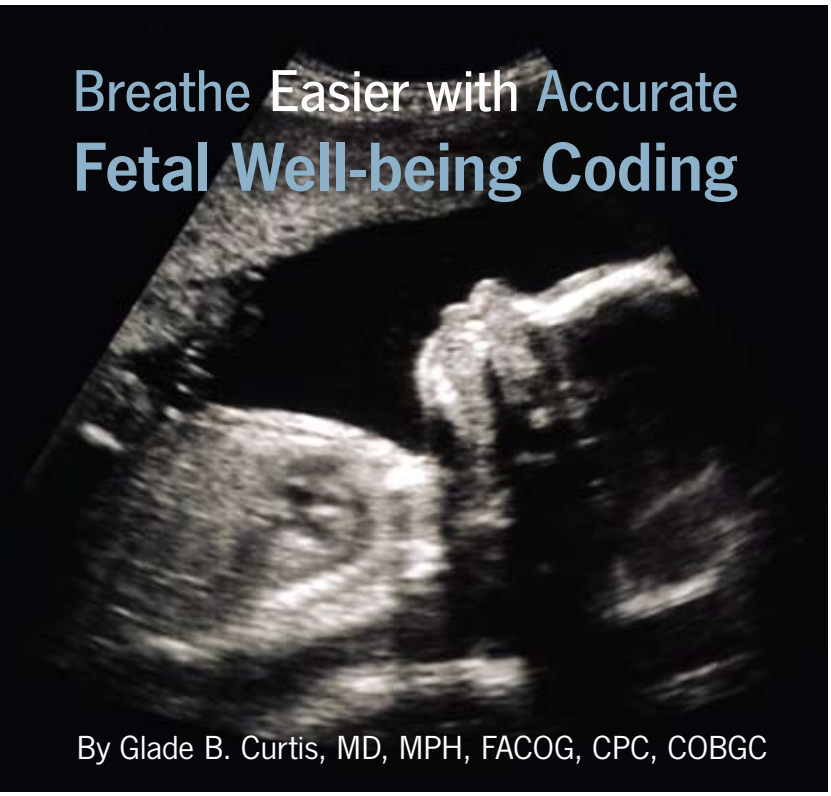


Breathe Easier with Accurate Fetal Well-being Coding

By Glade B. Curtis, MD, MPH, FACOG, CPC, COBGC

Ensure correct code choices to eliminate payment doubts.

APPRENTICE

When a patient is pregnant, nine months can feel like a lifetime. It is an exciting and often scary adventure. While the miracle of pregnancy produces changes in a mother's body, it is normal for her to have concerns about the developing baby and overwhelming new responsibilities. The number one question prospective parents ask is, "When can I have an ultrasound to tell if I'm having a boy or a girl?" The next most common question is, "Will my baby be okay; will it be normal?"

Tests and procedures may be performed to evaluate the pregnancy and, more specifically, the developing fetus. Testing begins early in pregnancy with routine blood tests and a Pap smear. It is also considered routine to perform an ultrasound exam in the first half of pregnancy, usually around 16 to 20 weeks. As the pregnancy progresses, other tests may be required such as a screening test for diabetes or tests using ultrasound or fetal monitors. These tests of fetal well-being are referred to as antenatal testing or antenatal fetal surveillance. Sometimes the terms prenatal or ante partum are used synonymously with antenatal. The goal of antenatal testing is to prevent fetal death and give reassurance of well-being.

Five Elements Determine BPP Code

A specific test that can be performed for reassurance of fetal well-being is the biophysical profile (BPP). The BPP is used in the third trimester, usually after 32 weeks (out of 40) gestation. This test is not useful earlier in pregnancy.

There are several indications for performing a BPP, including: diabetes, hypertension, heart disease, oligohydramnios, polyhydramnios, isoimmunization, decreased fetal movement, previous fetal demise, accident or injury, intrauterine growth restriction (IUGR), high-risk pregnancy, postdate pregnancy, and multiple gestation.

A full BPP consists of five elements, each of which is scored either "0" or "2." A perfect score is 10, often reported as "10 out of 10." A high score is reassuring, a low score is worrisome.

Of the five BPP elements, four are ultrasound evaluations. The final element is a non-stress test (NST) performed with a fetal monitor. Specifically, the five elements of the BPP are:

1. **Fetal breathing movements:** One or more episodes of fetal breathing movements for 30 seconds or more within 30 minutes are evaluated via ultrasound.
2. **Fetal movement:** Three or more discrete body or limb movements within 30 minutes are evaluated via ultrasound.
3. **Fetal tone:** One or more episodes of a fetal extremity extension with return to flexion, or opening or closing of a hand, are evaluated via ultrasound.
4. **Amniotic fluid volume determination:** A single vertical pocket of amniotic fluid exceeding 2 cm is considered adequate and is determined via ultrasound.
5. **NST:** A non-stress test is performed with a fetal monitor and is based on the fetus' heart rate accelerating with fetal movement.

For a full BPP, report 76818 *Fetal biophysical profile; with non-stress testing*. When an obstetrician performs all BPP elements except the NST, report 76819 *Fetal biophysical profile; without non-stress testing*. Code 76819 is sometimes referred to as a "limited BPP."

Avoid Common Coding Hazards

When an obstetrician performs the NST and a radiologist performs the other BPP elements, the obstetrician reports the NST (59025 *Fetal non-stress test*) and the radiologist reports 76819. This is a frequent problem area because code 76818 includes the NST, a test performed with a fetal monitor. Radiology departments usually don't have a fetal monitor and don't evaluate NSTs.

A common reporting mistake is confusing a "reactive fetal heart rate" with a "reactive NST." They are not the same. The first is a brief observation with ultrasound (as part of 76818 or 76819), while the reactive NST requires 20 plus minutes of fetal monitoring and interpretation. Many obstetrics/gynecology (OB/Gyn) offices have ultrasound machines and a fetal monitor and are equipped to perform a full BPP (76818).

There may be times when it is appropriate to separately report a BPP and an ultrasound performed during the same session—such as when a BPP is performed, but fetal presenta-

tion is also in question (such as with a breech or twin pregnancy). These are distinct examinations: An ultrasound is an anatomic exam, while a BPP is a physiologic exam.

In many instances, only an NST and an amniotic fluid index (AFI) are performed. In this case, neither BPP code applies because only two elements were done. Instead, report separately the NST (59025) and AFI (76815 *Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses*).

Good Documentation Eases Coding Worries

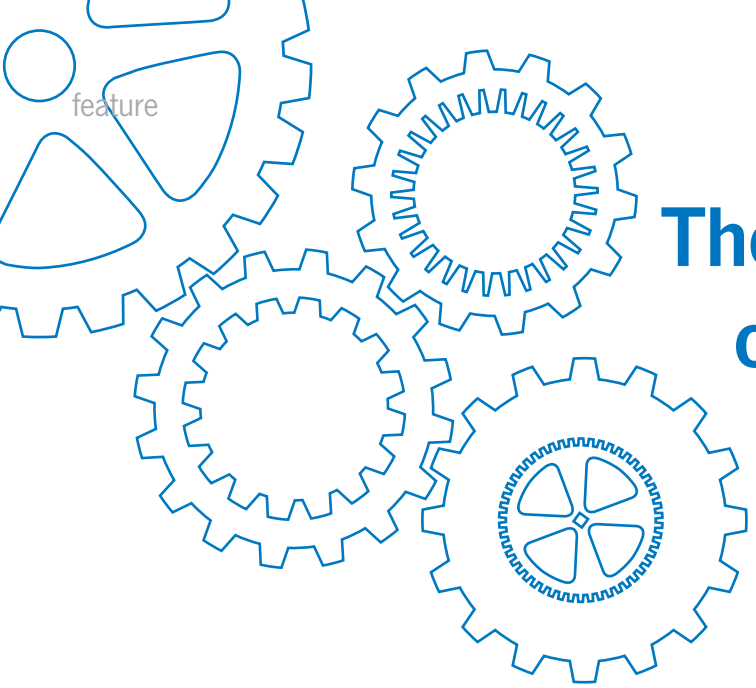
Documentation is critical and should clearly indicate the medical necessity for performing the BPP with ICD-9-CM diagnosis codes. The individual elements and scores should be documented with the total score from the BPP, such as, "the BPP is 8 of 10" in the case of 76818, or "the BPP is 6 of 8" with 76819. Some payers require manual documentation review in the medical record for payment of 76818 or 76819.

Frequently, OB charts used for prenatal care don't allow enough room to record information in addition to the basic prenatal visit. Encourage the provider to document the elements of the BPP. Suggest an extra sheet of paper, a stamp, or a form for BPPs requiring only a check or marking a box. For example:

Biophysical Profile (BPP) *(check/score the elements provided)*
☐ Movement:
☐ Tone:
☐ Breathing:
☐ AFI:
☐ NST:
BPP Score

A similar notation system can be established for electronic records. Most providers will listen if you make it clear that this documentation is required for payment.

Glade B. Curtis, MD, MPH, FACOG, CPC, COBGC is Board Certified in OB/Gyn and a fellow of the American College of Obstetricians and Gynecologists with more than 20 years experience, including delivery of more than 5,000 babies. He is chairman of the Medicaid Sterilization, Abortion and GYN Surgery Committee, with more than five years experience working for the State of Utah Department of Health Division of Healthcare Financing. He has spoken at conferences and has taught coding seminars and workshops for more than 13 years. Dr. Curtis is co-author of 17 titles relating to child birth and child care, selling over 5 million books, *Your Pregnancy Week by Week* and *Your Baby's First Year Week by Week*.



The Driving Components of E/M Level Selection

Combine the key components to determine the appropriate code.

By G. John Verhovshek, MA, CPC

Over the past three months, we've discussed the three key components of an evaluation and management (E/M) service—history, examination, and medical decision making (MDM)—and how to determine the appropriate level for each (for example, how to differentiate a problem-focused exam from an expanded problem-focused exam), as detailed under either the 1995 or 1997 Documentation Guidelines for Evaluation & Management Services. This month, we'll put it all together to illustrate proper reporting of an overall E/M service level.

Resource tip: The *Evaluation and Management Service Guide* is a helpful summary of E/M components found on the Centers for Medicare & Medicaid Services' (CMS) Web site at www.cms.hhs.gov/MLNProducts/Downloads/eval_mgmt_serv_guide.pdf.

Let Code Descriptors Guide You

CPT® code descriptors clearly spell out the unique requirements for each E/M service category and service level. For example, per the CPT® code descriptor, a level III, established patient office visit (99213) requires at least two of these three key components: An expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. By contrast, a level III outpatient consultation for a new or established patient (99243) requires these three key components: A detailed history, a detailed examination, and medical decision making of low complexity.

Five categories of E/M service require the documentation to support at least two of the three specified components to assign an overall E/M service level. In addition to established patient office visits (99212-99215), other E/M categories requiring only two of three key components are:

- Subsequent hospital care (99231-99233)
- Subsequent nursing facility care (99307-99310)
- Established patient, domiciliary care (99334-99337)
- Established patient, home care (99347-99350)

Note: All of these E/M categories involve subsequent care and/or established patients.

Case in Point

Let's consider, for example, that Mary S. is an established patient seeing her family physician with a new complaint. The physician documents the following:

Chief Complaints/Concerns

- DIZZY/LIGHTHEADED: For 2 months. Gets palpitations at times. Gets tightness in chest and also gets diaphoretic and dizzy. No nausea. Only two coffees/day.
- PAIN IN BOTH ARMS: Occurs at times. Got a treadmill for Christmas and gets shortness of breath at times when using it.
- CHEST ACHES: Tightness.

Family History

Reviewed

Review of Systems

Constitutional: Positive for fatigue
Respiratory: Positive for dyspnea
Cardiovascular: Negative for edema, orthopnea, PND, Positive for chest pain, dyspnea palpitations
Vital Signs: Bp Syst, 120; Bp Dias, 86; Weight Lb, 155

Physical Exam

General/Constitutional: No apparent distress. Well nourished and well developed.

Nose/Throat: Mucous membranes normal. Oropharynx appears normal. No mucosal lesions.

Neck/Thyroid: Supple, without adenopathy or enlarged thyroid.

Respiratory: Normal to inspection. Lungs clear to auscultation.

Cardiovascular: Regular rhythm. No murmurs, gallops, or rubs.

Musculoskeletal: No abnormalities

Assessment/Plan

- Chest pain acute: EKG and set up nuclear TM. Labs drawn. If TM negative, get ECHO.

E/M CPT® Descriptions

99201—Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family

99213—Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family

99214—Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family

99215—Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family

99243—Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family

- Fatigue, NEC acute, as above
- SOB acute, as above

For the purposes of this example, we'll judge the above E/M service using the 1995 E/M documentation guidelines.

First, look at the history. The history of present illness (HPI) describes location, duration, timing, context, and associated symptoms. The HPI is extended if at least four of the eight elements that quantify HPI are documented.

The review of systems (ROS) includes respiratory, constitutional, and cardiovascular systems. An extended ROS requires a documented review of at least two of the 14 organ systems. The documented ROS here does not rise to a complete ROS level, which requires documented review of at least 10 organ systems.

The physician reviews the family history only. This would qualify as a brief past, family, and social history (PFSH).

All three elements of history must support the work level to meet the overall history level requirement. The lowest element within the history component always determines the overall history level. In this case, the brief PFSH and extended ROS are together the lowest elements, which correlate to a **detailed** overall history level.

Next, consider the exam. Under the 1995 guidelines, extended examination of the affected body area(s) and other symptomatic or related organ system(s)—as documented here—qualifies as a **detailed** exam.

Finally, evaluate the MDM. The MDM level in this case is moderate. The patient has a new problem requiring additional workup, with a **moderate** amount and complexity of data for review, and a moderate risk level.

To meet the service level for an established patient office visit, documentation must support two of three components specified in the code descriptor. In this case, the moderate MDM, detailed history, and detailed exam all support a level IV service, 99214.

When All Three are Required

Nine E/M service categories require you to meet all three of the specified components to assign an overall E/M service level. These include new patient or initial service categories, among others:

- New patient office visits (99201-99205)
- Hospital observation services (99218-99220, 99234-99236)
- Initial hospital care (99221-99223)
- Office (99241-99245) and initial inpatient (99251-99255) consultations
- Emergency department services (99281-99285)
- Initial nursing facility care (99304-99306)
- New patient, domiciliary care (99324-99328)
- New patient, home care (99341-99345)

For these E/M service categories, the lowest individual component (whether history, exam, or MDM) will always determine the overall E/M service level.

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Case in Point

Let's consider another example, where Jim G. is a new patient in the office. The physician documents the following:

CHIEF COMPLAINT: Left knee pain.

HISTORY OF PRESENT ILLNESS: A 67-year-old male is seen today as a new patient with left knee pain for approximately one month. He offers a catching sensation. Pain is primarily through the medial joint line. There is no significant instability. He is currently taking Celebrex for pain. He offers prior history of automobile accident in the 1980s. He is currently not performing any home exercises, nor has he undergone any recent injections.

CURRENT MEDICATIONS: Metformin, metoprolol, Lipitor, glipizide, Synthroid, Altace, ranitidine, Celebrex.

ALLERGIES: Sulfa, penicillin, and IVP dye.

PAST MEDICAL HISTORY: Significant for hypertension, diabetes, thyroid disorder, previous history of a stroke, cardiac disease.

REVIEW OF SYSTEMS: He currently denies any unstable angina, no pulmonary disorders or productive coughs. No history of renal dysfunction. Denies gastric ulcer. No unexpected weight loss or constitutional signs of infection. No known coagulopathies.

SOCIAL HISTORY: Denies tobacco and alcohol use. He is retired.

FAMILY HISTORY: Diabetes, heart disease, and cancer.

PHYSICAL EXAMINATION: He has pronounced retropatellar crepitation. There is bogginess of the synovium, tenderness through the medial joint line. Ligamentous evaluation is stable. He has varus alignment of the knee. He is intact to sensation, has palpable pulses.

ANCILLARY STUDIES: AP, lateral, and sunrise views ordered and interpreted today. They reveal calcification within the vascular structures. There is decreased joint space through the medial compartment where he has near bone-on-bone contact, flattening of the femoral condyles, no fractures noted.

IMPRESSION: Left knee pain secondary to underlying degenerative arthritis.

PLAN: We will proceed with a course of joint lubrication therapy and physical therapy. Injection series was ordered. In the interim, he may continue activities as comfort allows, limiting repetitive stair-climbing and kneeling.

Now let's consider the E/M portion of this note using the 1997 documentation guidelines.

The HPI is *extended* (noting location, quality, duration, and modifying factors). The ROS is *extended*, covering constitutional, cardiovascular, respiratory, gastrointestinal, genitourinary, musculoskeletal, and hematologic/lymphatic. The PFSH is *complete*, covering past, family, and social history. Together, these elements add up to a **detailed** history. The exam, which is limited to the area around the knee, qualifies as **problem-focused**. MDM in this case is **straightforward**: This is a new problem, the physician orders several studies, and the level of risk is low.

Because all three required key components must be present for a new patient visit, the lowest key component will decide the overall services level. In this case, the problem-focused exam relegates the service to 99201.

Important: Although this article focuses on E/M level selection using the three key components of history, exam, and MDM, time may be considered the controlling factor to qualify for a particular E/M service level, "When counseling and/or coordination of care dominates (more than 50 percent) the physician/patient and/or family encounter…," according to CPT® guidelines. This would include face-to-face time in the office or other outpatient setting, or floor/unit time in the hospital or nursing facility, and includes time spent with parties who have assumed patient care responsibility or decision making whether or not they are family members.

For more information on time as the controlling factor in E/M level selection, see "Correctly Code Patient Counseling" by William Galvin, CPC, on page 21 of the March 2009 *Coding Edge*.

G. John Verhovshek, MA, CPC, is AAPC's director of clinical coding communications.

Medical Necessity, not MDM, Drives E/M Level Selection

A popular coding myth is when selecting an E/M service level based on two of three key components, at least one of the deciding components must be MDM. For example, if the physician documents a detailed history, a detailed exam, and MDM of low complexity, the coder may be reluctant to report 99214—even though this E/M service level calls for two of three components to include at least a detailed history and detailed exam (which were documented in this case).

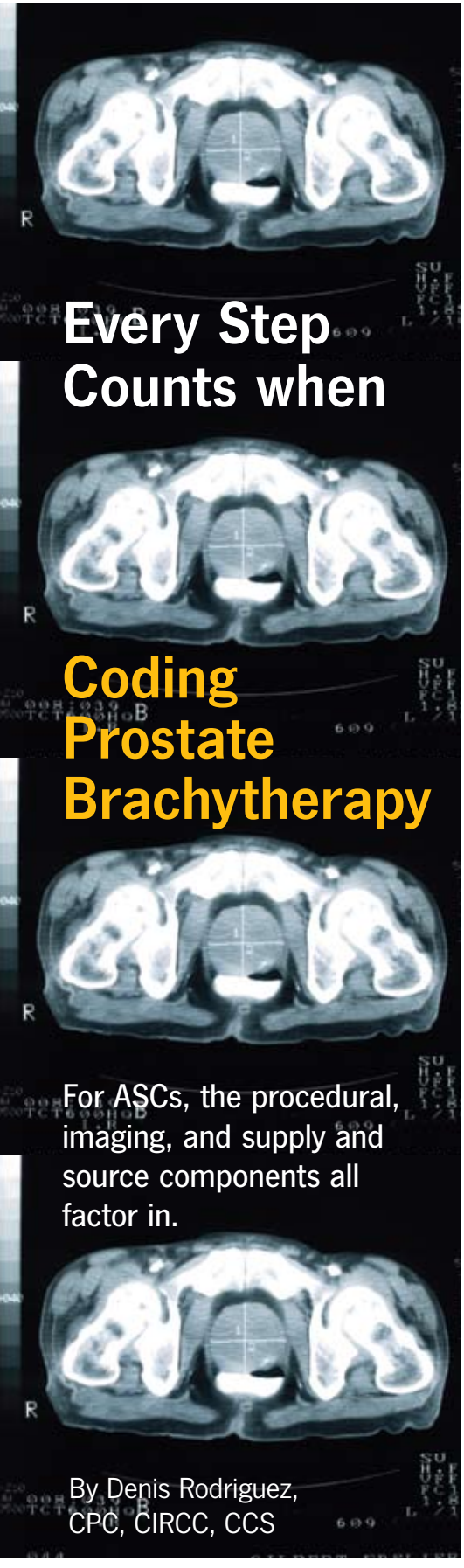
CPT® accords no special status to MDM over either the history or the exam; and E/M code descriptors that require at least two of three components *do not* specify that one of the qualifying components must be MDM. In the first example given in the main article, for instance, 99214 may be appropriate even though MDM was not used as one of the key components to assign the service level. Similarly, a high MDM level does not by itself determine the overall service level.

The single overriding factor controlling E/M level selection—and all medical services and procedures—is *medical necessity* (see Medicare *Claims Processing Manual*, 30.6.1.A: www.cms.hhs.gov/manuals/downloads/clm104c12.pdf). If documentation supports medical necessity for a comprehensive history and a comprehensive exam for an established patient in the office, 99215 is the correct code choice, regardless of the documented MDM level.

Problems do arise when the provider documents a history and exam not supported by medical necessity. The *Claims Processing Manual* (30.6.1.A) states clearly, "It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. *The volume of documentation should not be the primary influence upon which a specific level of service is billed.*"

A common cold, for instance, wouldn't normally call for a high-level exam or history. In such a case, a low level of MDM may be a clue that a detailed or comprehensive history and exam aren't medically necessary and you should not select an E/M level based on the superfluous documentation. If the nature of the presenting problem justifies the documented history and exam, however, MDM need not be a factor for those services requiring only two of three components for E/M level selection.

–G. John Verhovshek, MA, CPC, is AAPC's director of clinical coding communications.



Every Step Counts when Coding Prostate Brachytherapy

For ASCs, the procedural, imaging, and supply and source components all factor in.

By Denis Rodriguez, CPC, CIRCC, CCS

Anyone associated with ambulatory surgical centers (ASCs) is aware of the sweeping changes the Centers for Medicare & Medicaid Services (CMS) has instituted to the facility payment system. Few procedures have undergone more changes than prostate brachytherapy.

Brachytherapy, also known as seed implantation, is generally an outpatient procedure used in the treatment of different kinds of cancer such as prostate cancer.

When coding for prostate brachytherapy performed in an ASC, think in terms of coding each component of the procedure. There are several separately reportable steps of the brachytherapy procedure and several supplies and implants with new codes.

Procedural Components

Using imaging guidance, prostate brachytherapy involves needles or catheter insertion through the perineum into the prostate. Radioactive sources (seeds) are then placed into the prostate via the needles.

A urologist often performs the needle placement portion of the procedure while a radiation oncologist/radiologist performs the source implantation. In some cases, though, one physician performs the entire procedure.

Whether one or two physicians perform the procedure, the facility coder assigns the same CPT® codes: 55875 *Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy* for the needle insertion (including cystoscopy at the same session), and 77778 *Interstitial radiation source application; complex* for the source implantation. Code 77778 is for complex source application, which, according to the September 2005 *CPT® Assistant*, is for application of more than 10 sources. Prostate brachytherapy normally involves application of between 40 and 150 sources.

The 2009 non-wage adjusted transitional payment is $1,376.65 for 55875 and $247.42 for 77778. This includes the code's procedural component and the imaging component.

Imaging Components

Imaging normally is performed throughout a prostate brachytherapy session. An ultrasound prostate volume study (76873 *Ultrasound, transrectal; prostate volume study for brachytherapy treatment planning (separate procedure)*) is often performed perioperatively. Ultrasound guidance for placement of the needles and sources into the prostate (76965 *Ultrasonic guidance for interstitial radioelement application*) is also performed. Fluoroscopic guidance (77002 *Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)*) is often performed in addition to ultrasound guidance.

The ultrasound prostate volume study (76873) is a separate procedure per the CPT® manual; however, it should not be reported separately as it is bundled into 77778 per national Correct Coding Initiative (CCI) edit rules.

Also per CCI edits, ultrasound and fluoroscopic guidance *do not* bundle into the main procedure codes (55875 and 77778). However, these codes are assigned payment indicator N1—meaning their payment is "packaged" or included in the payment ($1,376.65) for the main code (55875). According to CMS, packaged codes should not be listed separately on a claim; rather their charges should be added to the main procedure's charge on the same line item.

For example, your facility charges $5,500 for code 55875 and $600 for code 76965-TC for the technical component of the service. There is no separate line item for code 76965-TC on the claim; however, the $600 charge is added to 55875's charge. The 55875 line item charge is $6,100 instead of $5,500.

Commercial payers generally have not yet incorporated the packaging concept for ASCs. A separate payment for 76965-TC may be available, as this code is not bundled into any other brachytherapy procedure.

Supply and Source Components

This year, ASCs can use HCPCS Level II C codes associated with brachytherapy needles and radioactive sources. These C codes were previously restricted to hospital outpatient departments paid through the Outpatient Prospective Payment System (OPPS).

Needles used in brachytherapy can be reported with C1715 *Brachytherapy needle*. Code C1715 is reported per needle, not per procedure. Code C1715 has an N1 payment indicator, so its payment is packaged into the main procedure code (55875).

Code brachytherapy sources to the appropriate C code as shown in Table A.

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Table A: Brachytherapy Sources C Codes

HCPCS Level II Code	Descriptor
C2638	Brachytherapy source, stranded, iodine-125, per source
C2639	Brachytherapy source, non-stranded, iodine-125, per source
C2640	Brachytherapy source, stranded, palladium-103, per source
C2641	Brachytherapy source, non-stranded, palladium-103, per source
C2698	Brachytherapy source, stranded, not otherwise specified, per source
C2699	Brachytherapy source, non-stranded, not otherwise specified, per source

Two codes were developed for sources without a HCPCS Level II code assigned: C2698 for stranded sources and C2699 for non-stranded sources. These codes should only be used for FDA-approved sources that consist of a radioactive isotope consistent with CMS' definition of a brachytherapy source eligible for separate payment (2006 Final Rule [71 FR 68113]).

When coding for brachytherapy sources, enter the total number of prescribed and acquired units for the beneficiary on the line item for the appropriate HCPCS Level II code. For stranded sources, code per source, not per strand.

If both stranded and non-stranded sources are implanted, report each type on a separate line item. For example, if 68 stranded iodine-125 sources and six non-stranded iodine-125 sources are implanted, report 68 units of C2638 and 6 units of C2639.

What if most, but not all, of the sources acquired for a patient are implanted? Medicare will cover all brachytherapy sources—implanted or not—under the following circumstances:

1. The sources were specifically acquired by the ASC for the particular beneficiary according to a physician's prescription consistent with standard clinical practice and high-quality brachytherapy treatment.
2. The sources that weren't implanted in the beneficiary weren't implanted in any other patient.
3. The sources not implanted were disposed of in accordance with all appropriate handling requirements.
4. The number of sources not implanted constitutes a small fraction of the total number of sources used.

Medicare should not be billed for non-implanted sources unless these circumstances are met. Note that commercial payers may have different guidelines for billing non-implanted sources; and Medicare payment for brachytherapy sources is at contractor-priced rates.

Associated Procedures

There are other procedures associated with brachytherapy that you may code in addition to those already described. Computer-generated, three-dimensional (3-D) reconstruction, for example, may be used for brachytherapy. Documentation is required with 3-D reconstruction and dose distribution. Base the scan images used for computer data entry on the implanted site's 3-D depictions. The source positions may be digitized directly from these images or the 3-D reconstruction, and the tumor volume and normal tissue image may be merged electronically. Code 77295 *Therapeutic radiology simulation-aided field setting; 3-dimensional* can be used to report this at a non-wage adjusted transitional payment of $409.36 for 2009. Note that simple 3-D representations by treatment planning computer programs derived from planar radiographic images are not sufficient justification for this code's use.

This year, ASCs can use HCPCS Level II C codes associated with brachytherapy needles and radioactive sources. These C codes previously were restricted to hospital outpatient departments paid through the OPPS.

When you perform basic dosimetry calculation during brachytherapy (the determination of dwell times other than those times estimated in the isodose plan), you can report code 77300 *Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician* (transitional payment of $37.87). Include the treating physician's prescription, as well as documentation of the calculation, in the patient's chart. CE

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Maintain NPP Reimbursement, Improve Practice Productivity

Follow NPP state licensing, scope of practice, and incident-to rules. By Julie E. Chicoine, Esq., RN, CPC

The Association of American Medical Colleges (AAMC) reports several studies and surveys demonstrating a growing shortage of physicians to meet the nation's current and future health care needs (www.aamc.org/workforce/recentworkforcestudies.pdf). In light of this trend, many providers, including physician group practices, increasingly look to nonphysician practitioners (NPPs) such as nurse practitioners (NPs) and physician assistants (PAs), to fill the void. Although both professionals are licensed under different state authorities (advanced practice nurses are licensed by a state board of nursing; whereas PAs are licensed by a state board of medicine), their education and training allow them to perform generally the same essential functions, such as: performing physical exams, making clinical decisions, ordering appropriate laboratory tests/procedures, and providing therapeutic or preventative health services for patients with acute or chronic diseases.

In hiring NPPs, however, many practices do not fully comprehend the regulatory issues governing their services, and do not utilize their professional role to its greatest potential. Medicare and private payers allow coverage for most services provided by these professionals. The information that follows summarizes key Medicare principles (*Medicare Benefit Policy Manual*, pub. 100-02, sec. 190, 200).

Resource tip: Although this article provides a basic high-level summary of Medicare rules and regulations with regard to NPPs and PAs, additional information is available on Centers for Medicare & Medicaid Services (CMS) Web site (www.cms.hhs.gov).

NP and PA Qualifications

To furnish covered services to a Medicare beneficiary, CMS requires NPs:

- Be a registered nurse (RN) authorized by the state in which services are furnished and practice as an NP in accordance with state law; and
- Be certified as an NP by a recognized national certifying body that maintains established standards for advanced practice nursing. (Examples include: the American Academy of Nurse Practitioners; American Nurses Credentialing Center; National Certification Corporation for Obstetric, Gynecologic, and Neonatal Nursing Specialties; Pediatric National Certification Board; Oncology Nurses Certification Corporation; AACN Certification Corporation, and; National Board on Certification of Hospice and Palliative Nurses.); or
- Be an RN authorized by state law to practice as an NP, and have a Medicare billing number as an NP by Dec. 31, 2000. NPs who apply for a Medicare billing number (National Provider Identification (NPI) number) for the first time on or after Jan. 1, 2003 must possess at least a master's degree in nursing.

As with NPs, Medicare requires PAs to have the following minimum qualifications:

- Graduate from a PA educational program that is accredited by the Accreditation Review Commission on Education for the Physician Assistant (its predecessor agencies, the Commission on Accreditation of Allied Health Education Programs (CAAHEP) and the Committee on Allied Health Education and Accreditation (CAHEA) (www.arc-pa.org/General/history.html); or
- Pass the national certification examination administered by the National Commission on Certification of Physician Assistants (NCCPA) (www.nccpa.net/); and
- Be licensed by the state in which the PA intends to practice.

Covered Services

Medicare limits coverage to services an NP or PA is legally authorized to perform in accordance with state law and regulations in which he or she is licensed. State licensing laws can vary, however, so NPPs should evaluate scope of practice limits carefully before relocating from one state to another. Reimbursement under Medicare Part B requires NP and PA services meet all of the following conditions:

- The services are considered to be physician's services if furnished by a doctor of medicine or osteopathy (MD or DO);
- The services are furnished by a person who meets the qualifications for NPs and PAs respectively as described earlier;
- The NP and PA is legally authorized to furnish the services in the state where they are performed;
- NP services are performed in collaboration with an MD/DO. PA services are performed under the general supervision of an MD/DO; and
- The services are not precluded from coverage due to statutory exclusions.

Noncovered Services

Services performed by NPs and PAs within state scope of practice laws may not be reimbursable if they are excluded from Medicare coverage due to medical necessity provisions. NPs and PAs, like other providers, should evaluate local and national coverage determinations, as well as key Medicare coverage provisions to ensure accurate reimbursement.

For purposes of this article, "nurse practitioner" or NP generally means a nurse who has completed a master's degree and additional clinical education to provide advanced practice nursing. Certified registered nurse anesthetists, nurse practitioners, clinical nurse specialists and certified nurse midwives all fall under the general definition of NP.

Collaboration/Supervision

With regard to NPs, Medicare defines "collaboration" as a process in which an NP works with one or more physicians to deliver health care services, with medical direction and appropriate supervision as lawfully required by the state in which the services are furnished. Where a state does not have laws governing collaboration, the NP should document for Medicare purposes his or her scope of practice and the relationships that he or she has with physicians to address issues that go beyond the NP's scope of practice.

Medicare clarifies, for reimbursement purposes, that collaboration does not require the collaborating physician to be present with the NP when the services are furnished, or to make a separately independent patient evaluation. Collaboration requirements are set by state law and vary from state to state.

Unlike an NP, a PA's supervising physician is responsible for overseeing and directing his or her professional services. The supervising physician does not need to be present while the PA performs services unless such physical presence is required by state law. Medicare does, however, require the supervising physician be immediately available to the PA for consultation by telephone, unless state laws or regulations require otherwise. State law requirements should be evaluated to verify the PA is complying with applicable state and Medicare rules and regulations.

Reimbursement

PA and NP payment for professional services is 80 percent of the actual charge or 85 percent of the Medicare Physician Fee Schedule (MPFS) amount. That, however, is where the similarities end.

NPs may be employees or independent contractors of a physician or physician group practice, for the physician or group practice to bill for their services. Medicare also permits NPs to bill the Medicare program directly.

PAs may not bill their services directly to Medicare. PAs have the option of selecting employment relationships (i.e., 1099 vs. W-2), but payment for his or her professional services must be made to a qualified employer. If the PA's employer is a professional corporation or other duly qualified legal entity (i.e., a limited liability corporation or limited liability partnership), properly formed, authorized and licensed under state laws, and permits PA ownership in the corporation or entity as a stockholder or member, the corporation or entity as the PA's employer may still bill for the PA's services, even if the PA is a stockholder or officer of the corporation or entity.

NPP Services Incident-to Physician Services

In some circumstances, the services of an NP or PA may be billed incident-to a physician's professional service. To be covered, services and supplies furnished by the NP and PA incident-to a physician's must be:

- An integral, although incidental, part of the physician's professional service;
- Commonly rendered without charge or included in the physician's bills;
- Of a type that is commonly furnished in physician's offices or clinics; and
- Furnished by the physician or by auxiliary personnel under the physician's direct supervision (See *Medicare Benefit Policy Manual*, pub. 100-02, chap. 15, sec. 60.1 for more information).

When pursuing reimbursement under the incident-to provisions, practices must follow the detailed and nuanced provisions of incident-to requirements, including but not limited to the requirement of direct supervision. That is, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the NP or PA is performing an incident-to service.

Medicare clarifies that incident-to services cannot be rendered by an NP or PA on a patient's first visit. Incident-to services cannot be billed for services rendered to hospital patients or to patients in a skilled nursing facility (SNF) who are in a Medicare-covered stay.

If the incident-to requirements are met, the services are paid as if the physician provided them. These services are reimbursed at 100 percent of the Medicare fee schedule. Examples of services rendered under this scenario generally include high volume, low acute services provided by physicians, including minor surgery, setting casts or simple fractures, reading X-rays, and providing other services to evaluate and treat a patient's condition. CE

Julie E. Chicoine, Esq., RN, CPC, has many years of health care experience with expertise in reimbursement, documentation, and coding issues. She has served both as in-house and external legal counsel for health care organizations providing guidance on a variety of health care regulatory issues. Julie serves as attorney and director for the Ohio State University Medical Center's compliance program. She earned a Juris Doctorate from the University of Houston Law Center and holds a Bachelor of Science and a nursing degree from the University of Texas Health Sciences Center at Houston. She has written and spoken widely on health care issues, and is an active member of the AAPC community.

Military Action Aimed at New ICD-9-CM Codes

Codes help with data collection to keep beneficiaries healthy.

By Jeanne Yoder, RHIA, CPC, CPC-I, CCS-P

PROFESSIONAL

Have you ever seen a new code and wondered, "Who's the crazy loon who asked for that code?" Hello! I'm Jeanne, and I work for the Military Health System (MHS).

Unlike much of the civilian sector's health care, the MHS is socialized medicine (a great system to be part). Many of us remain happily in the military health care system from the time we join the military service until we die. Because we, unlike private insurance plans, don't have members entering and leaving our program, long-term illness and injury prevention is always the best investment. It's a win/win situation for all—beneficiaries because they stay healthy; the military because our people are on duty, not home sick; and our country because we spend less money caring for diseases that could have been prevented. In an ongoing mission to keep our beneficiaries healthy, we need data—and that's why the military asks for so many disease and injury prevention-related codes.

For instance, a few years ago, as a way to help identify beneficiaries who had weight concerns but who weren't obese, we asked for a code for "overweight" (there was already a code for obesity). Because it's easier to lose 20 pounds than to lose 50 pounds, we wanted to help our patients avoid obesity and its common, unfortunate sequelae such as diabetes, hypertension, and knee/ankle pain. To help, we needed an easy way to identify them—and so 278.02 *Overweight* became a code.

Last year, personal and family history of deployments codes V61.01, V61.02, V62.21, and V62.22 were added to ICD-9-CM at our request.

This year, military requests were associated with new codes in two basic categories: traumatic brain injury (TBI) and its neurologic sequelae (799.2x), and external cause of injury tracking E codes.

TBI Codes Get Specific

Between 2003 and 2007, approximately 40,000 service members were diagnosed with TBI due to the Iraq War. TBI is the hallmark injury in this war. TBI frequently is linked to improvised explosive devices (IEDs). In the past, shrapnel would have caused most significant injuries. Due to this war's improvements in body armor and protective devices, it's shock waves causing the injuries. A human head, balanced on a comparatively thin neck with muscles only meant to turn the head, is not designed to withstand these shock waves. When the head encounters shockwaves, it rapidly accelerates away from the blast, causing the brain to strike the inside of the skull. Frequently, the rapid head acceleration/deceleration creates damage—ranging from subtle to life shattering—without visible wounds.

Some soldiers experience TBI sequelae manifested in changes in cognition, behavior, or personality. These changes needed separate codes from the cognitive/behavior/personality mental health codes. Superficially, the symptoms appear to be similar, but that would be like saying a headache caused by a ruptured aneurism is similar to a headache due to lack of sleep. TBI sequelae required separate collection and easy identification to optimize care and to determine the most effective treatment. We

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needed post-TBI conditions codes for patients who did not have mental health cognition/behavior/personality issues and experienced TBI, and now have one or more of the conditions. Mixing mental health and neurologic cognitive/behavior/personality issues was not helping our military service members or those individuals injured in motor vehicle accidents, sports injuries, and falls.

One million Americans are treated in U.S. emergency departments for TBI each year, and an estimated 5.3 million are living today with a disability related to TBI. Having a way to collect data specific to TBI and its sequelae is the first step in determining optimal treatment regimens, and limiting long term harm to military service members and others with TBI.

The Veterans Administration (VA) is mostly responsible for developing the TBI codes. Dr. Kyle Dennis kept all interested parties (including the military representatives) on track until all agreed. There was a lot of negotiating, and a consensus has not been reached on all issues (such as the definition of mild, moderate, and severe TBI).

On Oct. 1, the 799.21-799.29 codes for the sequelae of TBI will be added to ICD-9-CM. We do a lot of screening for TBI, so we asked for V80.01 *Special screening for traumatic brain injury* to track who was screened, and to explain the medical necessity for the service. Code V15.52 *Personal history of traumatic brain injury* will be used with new 799.2x codes to show the link between the cognitive/behavior/personality signs and symptoms code and the TBI. We are hoping ICD-10-CM will have space in the neurologic section for these codes so we won't need two codes (e.g., V15.52 and 799.21) to explain the signs/symptoms are of neurologic origin.

Why are the new codes in the 799.2x range? Most of our team wanted the new codes added to the neurological section rather than the mental health section. The team reasoned neurologic changes—not mental health issues—were causing the behavior/personality/cognition changes. But, trying to find appropriate space in the neurology codes was a big problem (Yes, we need ICD-10-CM!). We worked with the National Center for Health Statistics (NCHS), part of the Centers for Disease Control.

Anyone could have commented on the proposal, attended the free Coordination and Maintenance Meetings in Baltimore for free AAPC continuing education units (CEUs), or commented based on the proposals posted to the NCHS Web site (www.cdc.gov/nchs/about/otheract/icd9/maint/maint.htm). Dr. Dennis addressed all comments.

External Injury E Codes Can Help Prevent Injury

Half of the new diagnosis codes for October 2009 are for external injury causes data collection. Data collection is used to develop ways to avoid injury to keep our beneficiaries healthy.

Until October 2009, there are three types of E-codes used for data collection.

1. The E mechanism codes: Just like other codes, documentation is required to assign E codes. For injuries, the most common documentation indicates the injury mechanism, which is why these are the most common E codes used. E mechanism codes include motor vehicle accidents, falls, striking or being struck by, poisoning, and abnormal reactions/effects.

2. The E location codes (E849.x): Less frequently, there is documentation of where the injury occurred. The E849.x codes have proven valuable for separating injuries occurring at work from those occurring at home or during a leisure activity. When using E location codes, they are usually coded after the E mechanism codes.

3. The E intent codes (generally between E859 and E999.1): These include self-inflicted, fight, and war-related injuries. The E intent codes aren't used frequently because most injuries are not intentional. And, even if the injury was intentional, the doctor may not be told it is intentional (the ever popular "I fell" to explain contusions on non-bony prominences - huh?). Only when we see the occasional "patient in fight" for the late Friday night emergency department patient is there documentation to support the E intent codes. We don't see it in the documentation, so these codes are usually not used.

To help keep our beneficiaries from injury, we need to know why various injuries occur by identifying injuries quickly and easily. To do so requires more and better provider docu-

In the past, shrapnel would have caused most significant injuries. Due to this war's improvements in body armor and protective devices, it's shock waves causing the injuries.

Half of the new diagnosis codes for October 2009 are for external injury causes data collection. Data collection is used to develop ways to avoid injury to keep our beneficiaries healthy.

mentation and needs expanded injury codes for different parameters. This year, two new parameters are added to the existing external injury causes. These two sets are very important and include E status codes and E activity codes. Some E intent codes, particularly those associated with war related injuries, have also been expanded.

E status Codes: Just because you have a job doesn't mean you're covered by your state workers' compensation nor may you be covered by a private workers' compensation insurance policy paid for by your employer. Many people work on family farms or family boats, and they aren't usually covered by worker's compensation.

To help keep workers' compensation premiums to a minimum and to help those without coverage, it's useful to know what injuries are happening to employees.

In the military, we have numerous employees—many more than just the active duty military. We want to find ways to prevent injuries. If an injury happens, we want to find the best way to treat the patient. We need to know what treatment will lead to a return of duty, and which may lead to a progression to permanent disability/impairment. Our goal is to have all patients returned to full, functional capacity. To do this, we need to know when, why, and where. E status codes help us find answers and in the future, decrease the total numbers of patients with permanent disabilities. We anticipate this code will be coded commonly after the E mechanism because doctors usually document when an injury is work-related.

E activity codes: Based on military documentation review, we frequently find injury documentation related to a specific sport. For instance, our data has shown for a long time the military could significantly decrease injuries occurring on base if we banned basketball. Unlike other major sports, basketball is played year-round, so injuries stay pretty constant. If we banned basketball, however, we suspect the decrease in injuries would be temporary. Our beneficiaries are usually healthy, energetic, young adults. If they could not play basketball, they would soon become involved in another sport. Overall, however, the health effects from playing basketball outweigh the injuries.

The E activity codes allow easy injury identification based on the sport involved. Easy injury data retrieval for specific sports helps identify ways to decrease injuries related to that sport. We anticipate that once the documentation is available, the E activity codes will be coded as frequently as the E mechanism codes. If documentation is available for both, the E mechanism code is sequenced first and the E activity code is sequenced second.

E military codes: The E military codes aren't used often by us, and probably will be used even less by you. So briefly, new E83x.7 codes were created for military watercraft accidents and codes greater than E990.1 were expanded. We don't anticipate a big upswing in injuries due to war operations from flamethrowers. Our reasoning for these codes is the U.S. military is part of North Atlantic Treaty Organization (NATO), and the military is obligated to collect data sufficient to submit reports using the standard NATO injury codes. When we move to ICD-10-CM, expect to see even more granularity in war-related injury codes. CE

Jeanne Yoder, RHIA, CCS-P, CPC, CPC-I, retired last year from the United States Air Force after 26 years. She is a contractor working for the TRICARE Management Activity. She presented at the 2006-2009 AAPC national conferences. Jeanne's goal is to have quality data to help make quality decisions. "Coding is documenting, only shorter."

Members Impacted by War

Thanks to members who responded to the Bulletin Board post calling for military personnel and loved ones serving our country in the military. Being involved in the military not only affects members' daily and personal lives; for some, coding careers are put on hold. Here are some of the responses received:

"I passed my certification exam three months before I deployed to Iraq. It is my second deployment as a member of the Tennessee National Guard and I am proud to be serving here. I am looking forward to joining my local coding community when I get home and starting on a new and exciting career."

Sergeant First Class (SFC) Cynthia Richardson, CPC-A

"I work for University Medical Associates at the Medical University of South Carolina. I have been in the Air Force Reserves for 28 years and have served in Iraq (2003-2004) and in Kuwait (2006) in support of the war."
E7 Master Sergeant Sherry Blackwell, CPC

"My husband, Sgt. Roger D. Hitz Jr. US Army Reserves, served in Iraq from 2006-07. He's been in the military eight years and just recently reenlisted for six more with my full support. He loves his job! Being a military spouse is a pride-filling and heart-wrenching position to hold. I am very proud of my husband and his fellow soldiers for the jobs they perform so selflessly to protect us and our freedoms at home."
Keri Hitz, CIRCC, billing/coding specialist, Indiana Vascular Institute at St. Francis

"I am a coder. My husband, SFC Phillip S. Vera, is serving overseas in Afghanistan. We are currently stationed in Germany. I feel being a military wife has somewhat affected my coding career. Moving overseas has made it difficult to find a coding job where we are currently stationed. The nearest coding jobs would be an hour away at the main hospital."
Noemi Vera, CPC

"My brother-in-law, Staff Sergeant Kenneth Walker, TAC-P is serving his third tour in Afghanistan. He served two tours during Desert Storm and is now with the Air Guard. Our family is proud of him for sacrificing himself for this country. We can't wait for him to come home: one, because we miss him and two, because my sister is pregnant with their fourth child. I proudly wear my 'support our troops' pin everywhere I go! I haven't forgotten to put it on yet."
Chanda Arscott, CPC-H, collections coordinator, Oregon Surgery Center, a division of Mercy Medical Center

"I'm the proud mother-in-law of Sgt. Anthony Lawton (Ty). May God bless him and his troops, today, and always! … I'm enrolled at Bucks County Community College and I'm so excited, at the age of 51, for certification and to broaden my medical horizon."
Betty Campbell, Bucks County Community College, Newtown, Pa.

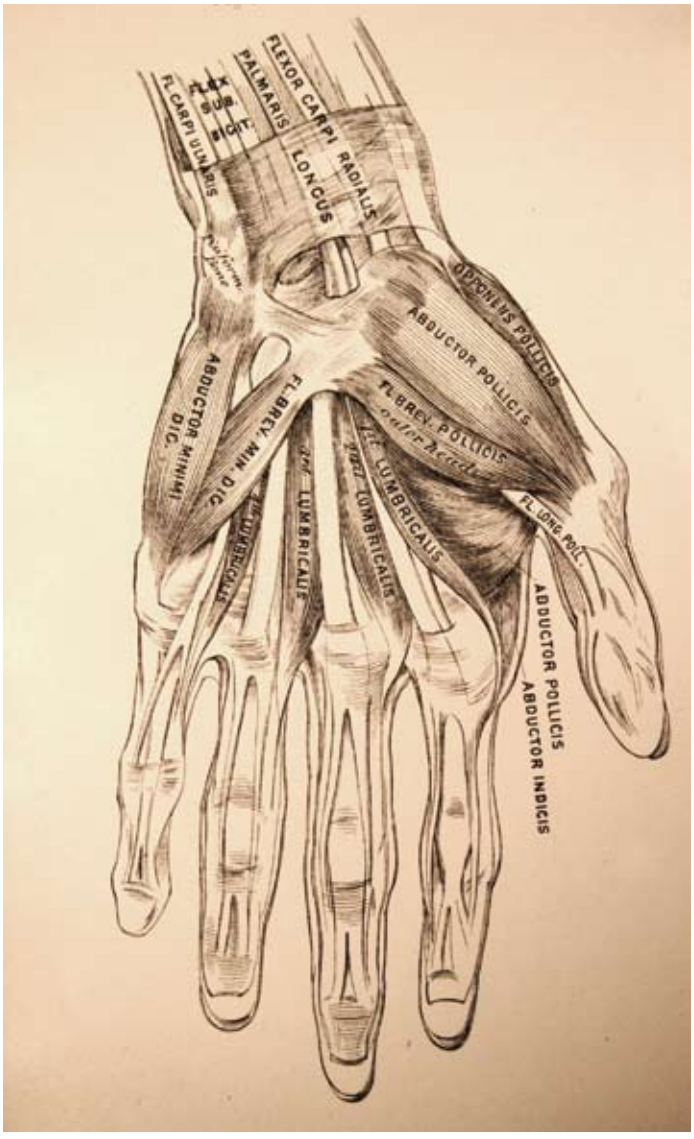
–Michelle A. Dick, senior editor

EXPERT

Case Studies Reveal Proper Carpal Tunnel Syndrome Coding

Dissect physician reports to get real-world coding knowledge.

By Gloria Galloway, MD



Median nerve entrapment at the palm-wrist segment, when associated with well-described symptoms, is known commonly as carpal tunnel syndrome (CTS). CTS diagnosis is based on clinical examination and nerve conduction (NC) and electromyography (EMG) studies to distinguish CTS from other disorders with similar symptoms. These electrodiagnostic studies also assist in the evaluation of other possible, associated conditions—such as a more generalized polyneuropathy—and detail the disorder's acuteness or chronicity in a patient (Dumitru, Daniel; Amato, Anthony A.; Zwarts, Machiel J., *Electrodiagnostic Medicine* 2001 2nd ed.).

EMG/NC testing guidance is based on the symptoms and physical examination signs for each patient. A brief history—including information on the patient's present complaint and associated medical conditions—should be taken.

A focused neurological examination is necessary to guide the electrodiagnostic study. A patient without associated medical conditions or complaints, who presents with paresthesias limited to the median distribution of one hand, usually requires only a few NC studies. EMG may be limited to one limb to obtain a reliable diagnostic interpretation (the EMG CPT® codes are based on the number of extremities tested, if cranial muscles are tested, or if fewer than five muscles in a limb are tested). In contrast, a patient presenting with unilateral or bilateral hand symptoms *in addition to* distal lower-extremity complaints and a known history of diabetes, usually requires nerve conduction testing and EMG studies of several limbs.

The American Association of Neuromuscular and Electrodiagnostic Medicine's (AANEM) *Recommended Policy for Electrodiagnostic Medicine* (www.aanem.org/practiceissues/recPolicy/recommended_policy_1.cfm) outlines recommended limits on the number of NC and EMG studies, by diagnosis, for 90 percent of patients. Refer to these recommendations to appropriately bill the number of motor and sensory nerves, F waves, and H waves tested, along with the number of units for each. Performing only necessary studies will keep cost and patient discomfort to a minimum.

The AANEM recommended policy for bilateral CTS suggests three motor and four sensory NC studies, and one limb EMG, as the maximum number of studies in 90 percent of such cases.

There may be exceptions to the AANEM's policy when more or less than the recommended number of studies is necessary. This is particularly true with multiple diagnoses and unusual clinical symptoms or signs. The case studies below describe typical coding, based on the diagnostic presentation's complexity.

Note: The CPT® codes described below are for use with standardized EMG equipment. The experienced judgment of the electrodiagnostic physician performing or supervising the studies is critical to evaluation and diagnostic interpretation of the study. Use different CPT® codes for studies using prefabricated electrode arrays placed by the practice staff after little training.

CASE 1: Patient with Uncomplicated Unilateral CTS

A 42-year-old is a right-handed male with no significant past medical history and on no medication. He has worked on the assembly line for a local manufacturing company for 15 years. Over the past three months, while assembling boxes, he complains of tingling and numbness in the right hand. He denies weakness or neck pain. Sometimes both hands will be tingling in the morning upon awakening.

There is normal muscle bulk over the hands, but sensory loss in the first three digits of the right hand and a positive Tinel's sign. Median palmar sensory studies reveal prolonged latency at the wrist and delayed nerve conduction velocity at the palm wrist segment, with normal amplitude. Median motor study on the right reveals a prolonged latency at the wrist with normal amplitudes and normal velocity in the wrist to forearm segment. Ulnar sensory study on the right reveals no abnormalities.

On the left, the only abnormality on median sensory study is a prolonged latency at the wrist. The median motor study is normal.

EMG of the right APB, FDI, pronator teres, FCR, FCU and bicep muscles reveal no abnormalities. The referring physician is informed of the electrodiagnostic interpretation so further workup and treatment can occur.

The electrodiagnostic physician bills the following CPT® codes based on the study performed:

- Three sensory nerve conduction studies (bilateral median and right ulnar sensory): 95904 *Nerve conduction, amplitude and latency/velocity study, each nerve; sensory* x 3 units;
- Two motor without F wave (median bilaterally): 95900 *Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F wave study* x 2 units; and
- One limb EMG: 95860 *Needle electromyography; one extremity with or without related paraspinal areas* x 1 unit.

Note: The AANEM recommended policy for bilateral CTS suggests three motor and four sensory NC studies, and one limb EMG, as the maximum number of studies in 90 percent of such cases.

CASE 2: Patient Presents with Multiple Complaints and Significant Medical History

This case lends itself to a greater number of electrodiagnostic studies for proper diagnosis.

A 62-year-old female is referred for electrodiagnostic evaluation with complaints of hand numbness bilaterally over the palmar aspect. She also has had numbness and tingling in the feet. She has a history of longstanding diabetes, hypothyroidism, and peripheral vascular disease. She takes aspirin daily, along with insulin, an oral hypoglycemic agent, thyroxin, and two antihypertensive medications.

On examination, she is obese with an elevated BMI, dry scaly skin, and hard nails. There is weakness to toe spread and finger extension bilaterally, and decreased sensation to vibration and pinprick in the distal lower extremities. DTRS are decreased throughout. Although her initial referral was for hand complaints, due to the symptoms in her legs, a thorough electrodiagnostic evaluation is also needed to assess the lower extremities.

On NC study, sural sensory responses are absent. Right peroneal motor and left tibial motor studies reveal slowing of nerve conduction velocity in the distal segments with borderline low amplitudes. Median palmar studies reveal no responses bilaterally. Median motor studies reveal loss of amplitude and slowing of nerve conduction velocity over the wrist segments, with normal velocities proximally. Bilateral ulnar motor and sensory nerve conduction studies are normal.

EMG of the right APB, FDI, pronator teres, EDC and deltoid reveal increased polyphasic motor units in the APB but are otherwise normal. EMG of the left APB, FDI, Pronator teres, FCU, and bicep reveal only increased polyphasic motor units in the APB. EMG of the Left ADH, EDB, lateral gastrocnemius, and vastus lateralis reveal increased polyphasic motor units in the ADH and EDB but are otherwise normal. EMG of the right ADH, EDB and anterior tibialis reveal increased polyphasic motor units in the right EDB only. The electrodiagnostic physician communicates the findings to the referring physician so further management of the patient ensues.

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The electrodiagnostic physician bills the following CPT® codes for two diagnoses—bilateral CTS and polyneuropathy—for which the patient was evaluated:

- Six sensory nerve conduction studies (bilateral sural, median, ulnar): 95904 x 6 units;
- Six motor without F wave (bilateral median and ulnar, right peroneal, left tibial): 95900 x 6 units; and
- Two limb EMG: 95861 *Needle electromyography; 2 extremities with or without related paraspinal areas* x 1 unit.

Under the AANEM recommended policy, in 90 percent of cases, polyneuropathy calls for a maximum of four motor and four sensory NC studies, and three limb EMG; for bilateral CTS, four motor and six sensory NC studies, and two-limb EMG. The diagnosis of polyneuropathy and bilateral CTS increases the number of maximum recommended nerve studies. CE

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Coding Edge—sidebar

Carpel Tunnel Syndrome at a Glance

CTS (ICD-9-CM code 354.0 *Carpal Tunnel Syndrome*) affects 2-3 percent of adults, with a much higher incidence among diabetic patients. Nearly 30 percent of diabetics without associated polyneuropathy suffer CTS; for those patients with generalized neuropathy, the incidence of CTS approaches 50 percent (Mendell, Jerry R.; Kissel, John T.; Cornblath, David R.: *Diagnosis and Management of Peripheral Nerve Disorders* (Contemporary Neurology Series, 59).

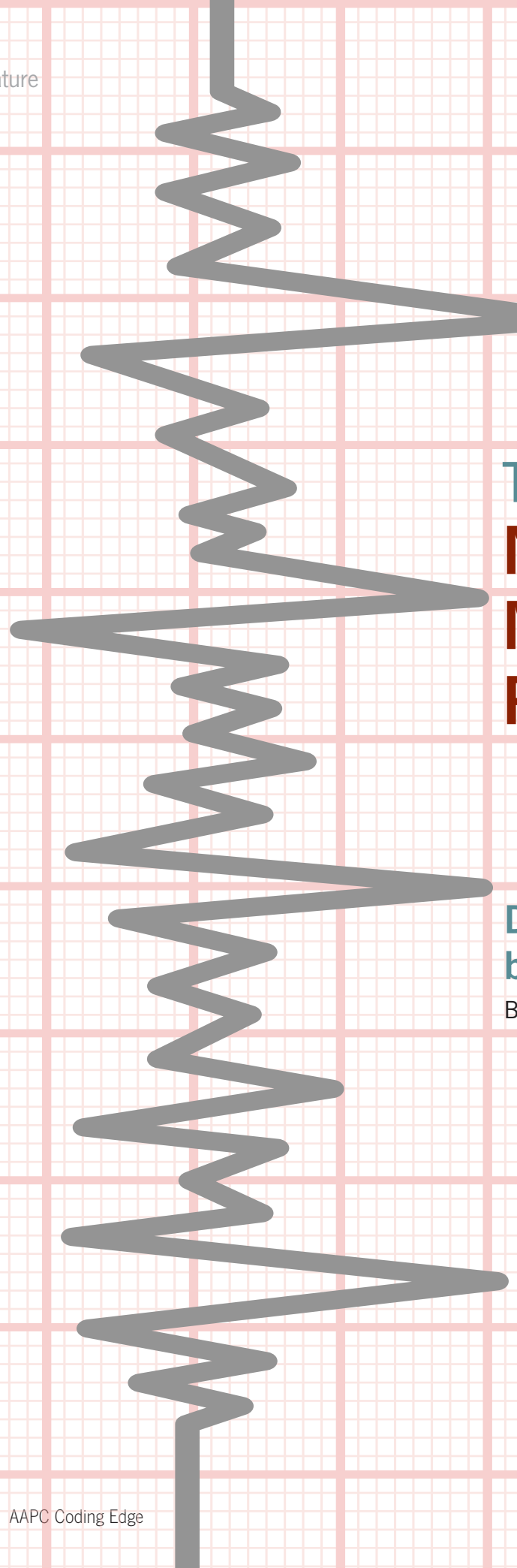
Clinical symptoms of CTS are based on median nerve innervation distribution involving the hand's first three digits and the median half of the forth digit, palm, and wrist, and may be reported over the distal forearm. Symptoms typically include paresthesias (a feeling of pins and needles), and pain and numbness in the median distribution. If left untreated, CTS may cause weakness, wasting of the thenar muscle, and loss of fine motor skills.

NC and EMG studies are useful diagnostic tests that complement CTS clinical examination and help to quantify and characterize abnormalities. A patient's symptoms, medical history, and physical examination findings guide electrodiagnostic procedures. A thoughtful approach spares the patient excessive, unnecessary, and potentially uncomfortable testing. CE

By Gloria M. Galloway, MD

advertising index

EXPERT



Take the *Stress* Out of Nuclear Medicine Myocardial Perfusion Studies

Don't let procedure uncertainties block better coding judgment.

By David Zielske, MD, CPC-H, CIRCC, CCC, CCS, RCC

When there is significant arterial blockage, the scan reveals decreased blood supply to the portion of the myocardium the diseased artery supplies during the initial perfusion study.

Nuclear medicine myocardial perfusion studies have been performed for many years under a variety of names such as thallium scan, nuclear medicine stress test, myocardial perfusion scintigraphy, sestamibi stress test, and exercise radioisotope scan. The key documentation elements needed to code the procedure appropriately are the type of imaging performed (single photon emission computerized tomography (SPECT) versus planar imaging), the number of studies performed, and the radiopharmaceuticals utilized.

Get the Facts First

Myocardial perfusion studies are performed to determine the presence and extent of coronary artery disease. This is based on evaluating decreased blood flow areas and the presence of reperfusion to the myocardium (versus an infarct that shows a "fixed" perfusion defect without reperfusion). The procedure is also used post-percutaneous stent placement or post-coronary artery bypass to determine the intervention effectiveness in improving blood supply to the previously ischemic myocardium.

When there is significant arterial blockage, the scan reveals decreased blood supply to the portion of the myocardium the diseased artery supplies during the initial perfusion study. Delayed images demonstrating reperfusion (or a reversible defect) suggest viable myocardium that will respond to revascularization is present. When there is total occlusion of the artery without significant collaterals, there is limited or no reperfusion on delayed images (a fixed perfusion defect) to that portion of the myocardium.

The myocardial perfusion study requires a radiopharmaceutical injection localizing to the myocardium. A gamma camera is utilized to quantify the radioactive energy emitted by the radiopharmaceutical in the myocardium and, with a computer, an image is produced showing the quantity of blood flow to the myocardium.

The study is usually performed in two separate phases: at stress and at rest. Which phase is performed first depends on the facility's protocol. On rare occasions, only the rest or the stress phase of the procedure is performed, instead of both phases.

For the stress phase of the study, the heart is stressed by walking on a treadmill or, if the patient can't tolerate physical exercise, by injection of a stressing pharmaceutical such as adenosine, dipyridamole, or dobutamine.

When the heart is sufficiently stressed, a radiopharmaceutical is injected and imaging is performed. In most cases, the imaging is performed with a gamma camera that revolves around the patient, known as SPECT or tomographic imaging. This allows imaging at the optimal angle to visualize the region of interest and eliminate common artifacts. The other method of imaging, which now is performed rarely, is termed planar imaging; the gamma camera only images a single plane at a time in a static position rather than rotating around the patient.

The resting phase of the study can be performed either by injecting a radiopharmaceutical while the patient is relaxing, and/or by imaging the patient subsequent to the stress phase, to determine how the blood redistributes in the myocardium as it recovers from the stress. In instances where sestamibi or tetrofosmin are used, a second radiopharmaceutical injection is performed for the resting phase.

Imaging, Number of Phases Determine Code

Report only one code from CPT® code series 78460-78465 for myocardial perfusion stress test. Code choice is based on whether the study was performed with SPECT or with planar imaging, and the number of study phases performed (single study, rest or stress only; or multiple studies, both rest and stress).

78460 Myocardial perfusion imaging; (planar) single study, at rest or stress (exercise and/or pharmacologic), with or without quantification

78461 Myocardial perfusion imaging; multiple studies (planar), at rest and/or stress (exercise and/or pharmacologic), and redistribution and/or rest injection, with or without quantification

78464 Myocardial perfusion imaging; tomographic (SPECT), single study (including attenuation correction when performed), at rest or stress (exercise and/or pharmacologic), with or without quantification

78465 Myocardial perfusion imaging; tomographic (SPECT), multiple studies (including attenuation correction when performed), at rest and/or stress (exercise and/or pharmacologic) and redistribution and/or rest injection, with or without quantification

If SPECT rest and stress studies are performed, report code 78465. In some facilities, the rest and stress phases are performed on different days. Report the two-day protocol study as one procedure code including the rest and stress. Do not report the rest and stress phases (78461 or 78465) separately, as two single studies, for a two-day study. Use the initial date the first procedure was performed as the service date for billing the study.

In addition to myocardial perfusion study codes, there are two wall motion or ejection fraction evaluation add-on procedure codes that, when performed, can be reported separately.

Wall motion determination requires specific cardiac chambers imaging during contraction to determine the motion, and function, of the myocardium. This is not an inherent component of the myocardial perfusion study and is reported separately with +78478 *Myocardial perfusion study with wall motion, qualitative or quantitative study (List separately in addition to code for primary procedure).*

Ejection fraction is a measurement to determine the volume percentage of blood ejected from the left ventricle in a single heartbeat. This can help physicians determine appropriate medications to improve cardiac function and limit congestive heart failure. When performed, report separately with +78480 *Myocardial perfusion study with ejection fraction (List separately in addition to code for primary procedure).*

Coding for pharmaceuticals varies according to the substance injected, as follows:

A4641 Radiopharmaceutical, diagnostic, not otherwise classified

A9500 Technetium TC-99M sestamibi, diagnostic, per study dose, up to 40 millicuries

A9501 Technetium TC-99M teboroxime, diagnostic, per study dose

A9502 Technetium TC-99M tetrofosmin, diagnostic, per study dose

A9505 Thallium TI-201 thallous chloride, diagnostic, per millicurie

J0152 Injection, adenosine for diagnostic use, 30 mg

J0395 Injection, arbutamine HCl, 1 mg

J1245 Injection, dipyridamole, per 10 mg

J1250 Injection, Dobutamine hydrochloride, per 250 mg

J2785 Injection, regadenoson, 0.1 mg

Report Cardiac Monitoring Separately

Heart stressing for a cardiac perfusion study's stress phase is performed with cardiac monitoring and close supervision. This component of the procedure is reportable separately with the appropriate code from series 93015-93018, depending on who performed the stress test.

Representing the technical component of a stress test, hospitals report code 93017 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; tracing only, without interpretation and report.*

Physicians report one of the following codes, depending on the portion of the exam performed:

93015 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report

93016 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; physician supervision only, without interpretation and report

93018 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only

Report separately the radiopharmaceuticals and stressing agents with the appropriate HCPCS Level II codes.

References:

National Government Services, Inc., *Article for Cardiovascular Nuclear Medicine - Supplemental Instructions Article* (A46181), 01/01/09

Palmetto GBA, LCD for *Cardiovascular Nuclear Medicine: Myocardial Perfusion Imaging and Cardiac Blood Pool Studies* (L28246), 02/26/09

Trailblazer Health Enterprises, LLC, LCD *for Cardiovascular Nuclear Medicine* 4C-57AB-R5 (L26583), 03/02/09

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Road Map to ICD-10-CM
Go the Extra Mile for ICD-10-CM Implementation Success

Go the Extra Mile for ICD-10-CM Implementation Success

Communication will set the wind in your sails.

By Deborah Grider, CPC, CPC-I, CPC-H, CPC-P, COBGC, CEMC, CPCD, CCS-P

As we prepare for the transition to ICD-10-CM, communication will be vital to manage expectations and identify who needs to do what and when. Whether this means one-on-one talks with your providers, staff, and key stakeholders to discuss ICD-10-CM or regularly scheduled status meetings with everyone in attendance, proper communication will ensure implementation success.

Effective Communication

Effective communication means you provide information in the right format at the right time with the right impact. It means that you provide necessary information and nothing more.

On smaller projects, communication is simple and requires little effort. The larger a project is, the more people get involved, and the more complex communication becomes. Larger projects require an advance communication plan, taking into account the individual needs of everyone involved. This is where a solid communication plan is essential to establish clear direction for ICD-10-CM implementation.

The Communication Plan

A communication plan allows you to communicate most efficiently and effectively to various constituents and provides priorities and milestones while preventing the delivery of an incorrect message to departments and staff. It provides focus, along with a sense of order and control, and will create a team atmosphere while establishing a chain of command.

A communication plan involves determining what the organization and its stakeholders' information needs are. For instance:

- What information should be collected?
- Who needs the information?
- When should the information be available?
- How should the information be formatted?

This process should include:

- Methods used to gather and store information
- Limits on who may give direction to whom, if any
- Relationships of reporting
- A list of stakeholders' contact information
- A schedule for information distribution
- A mechanism to update the plan as the project progresses

Important: The best time to develop a communication plan for your organization's ICD-10 implementation is now. Delay could hinder your final goals and objectives.

When developing a communication plan, first determine the project stakeholders. Identify the people or groups within the organization who will need information and determine their communication requirements. For example, a manager may need status updates more often than physicians and staff. Steering committee or project team members may need more information than others about project status, strategy, or vision.

Communication can take many forms. In each step, plan how to fulfill the communication needs for each department, employee, stakeholder, etc. When possible, streamline the process by looking for ways to communicate that will cover more than a single department's needs.

The communication plan sets the information exchange framework for ICD-10-CM implementation. It serves as a guide for communications throughout the project and should be updated as communication needs change. When creating your plan, identify and define the roles of people involved in the project. Include a communications matrix to map the communication requirements of the project.

The following steps will help you develop a communication plan for the implementation of ICD-10 in your organization.

Empower a Point Person or Project Manager
This person is responsible for ensuring successful implementation within the organization. He or she will update status reports, set up meeting schedules, take meeting notes, and manage the communication process.

Evaluate Current Communication Methods
Determine what departments or areas are doing to relay the ICD-10 messages to their department, providers, or staff. Perform an assessment of what each communication activity should achieve, and evaluate the effectiveness of each business area of ICD-10 implementation communication activity. Evaluate the communication capacity the organization has, determine

The best time to develop a communication plan for your organization's ICD-10 implementation is now. Delay could hinder your final goals and objectives.

what staff can be used for the project, and consider the time involved. Consider the incurred cost for additional communication resources.

Define Objectives and Goals

Your plan's objectives should include:

- ICD-10 code awareness;
- Implementation steps already initiated;
- Channels for communicating progress milestones;
- Identification of business areas needing improvement and what the problems are; and
- An awareness of barriers and challenges in the implementation process.

You can define the goals as a work program for each objective. Goals include general programs your communication plan will use to achieve these objectives. Identify how information will be gathered, and who is affected. Keep in mind: One of the important elements of successful implementation is to build awareness.

Identify Effective Communication Tools

Decide on the tools you'll use to accomplish ICD-10 goals. Be creative in your choice, but don't overlook the obvious and the easiest, such as e-mail updates, project status reports, staff or departmental meetings, etc. Keep your tools simple and easy for all members in the organization to use and comprehend.

Determine how much effort is required for each communication method within the organization. Some activities might be relatively easy to perform while others require more effort. If the communication is ongoing, estimate the effort over a one-month period. For instance, a status report might take one hour to create, twice a month. The total effort would be two hours.

Some communication activities are more valuable than others. Prioritize and determine which activities provide the most value for the least cost. If a communication activity takes a lot of time and provides little communication value, discard it. If a communication option takes little effort and proves to be valuable, include it in the final communication plan. If a communication activity is mandatory, include it no matter the cost. If a mandatory activity is time consuming, try negotiating with the stakeholders to find a less-intensive alternative.

Establish a Timetable and Evaluate Results

Once the objectives, goals, audiences, and tools are identified, quantify the results in a communication template, outlining what communication projects will be delivered and when. Designate logical time periods (monthly, weekly, etc.) for objectives' completion to help keep organized and on track. Build into your ICD-10 implementation communication plan a method for measuring results, such as periodic status reports on completed project work, departmental reports for presentation at staff meetings, and/or periodic senior management briefings. In a small medical practice, a management briefing might be a meeting to discuss progress with providers.

Awareness is Key

Bring ICD-10-CM awareness to your organization by communicating, mentoring, using question-and-answer sheets, and distributing other pertinent information to build confidence and enthusiasm in the project. A communication plan eases transition anxiety and keeps the entire organization involved and excited about the project.

The AAPC has developed a three-day ICD-10 Implementation Training Program for health plans and medical groups. Distance learning modules, webinars, and workshops will be available in 2010 at a reasonable cost to assist in ICD-10 implementation. For more information or to schedule training, please contact the AAPC at 800-626-2633 or send me an email at deb.grider@aapc.com.

As an added bonus, you can keep track of your personal ICD-10 implementation progress on the AAPC's Web site. Simply log on to your member page and, under ICD-10 Preparation, choose an option that best describes your organization from the dropdown menu. Click the Save button to view your personal implementation plan timeline and checklist.

Next time: Conducting an Impact Analysis … CE

Deborah Grider, CPC, CPC-I, CPC-H, CPC-P, COBGC, CEMC, CPCD, CCS-P is the AAPC's vice president of strategic development and the former AAPC National Advisory Board president. Deborah is currently writing the ICD-10-CM Implementation Guide.

Establish Patient Status at a New Location

Consider the three-year rule and specialty when deciding how to code.

By Katherine Abel, CPC, CPC-I, CMRS

Member **Stacey Enlow, CPC**, recently inquired, "Doctor X was in a group medical practice that dissolved. He now is in a solo practice with a new tax ID. Are patients from the previous practice 'new' or 'established' to his new practice?"

The short answer is: Established now if established before. Location doesn't affect a patient's "new" or "established" status.

The June 1999 issue of American Medical Association's (AMA) *CPT® Assistant* provides guidance on this scenario with the following example:

"Consider Dr A, who leaves his group practice in Frankfort, Illinois and joins a new group practice in Rockford, Illinois. When he provides professional services to patients in the Rockford practice, will he report these patients as new or established?

"If Dr A, or another physician of the same specialty in the Rockford practice, has not provided any professional services to that patient within the past three years, then Dr A would consider the patient a new patient. However, if Dr A, or another physician of the same specialty in the Rockford practice, has provided any professional service to that patient within the past three years, the patient would then be considered an established patient to Dr A.

"Remember, the definitions include professional services rendered by other physicians of the same specialty in the same group practice."

CPT® applies the "three year rule" to determine new vs. established status. A patient is established if any physician in a group practice (or, more precisely, any physician of the same specialty billing under the same group number) has seen that patient for a face-to-face service within the past 36 months. The CPT® manual contains a helpful "Decision Tree for New vs Established Patients" section in the *Evaluation and Management Services Guidelines* (near the beginning of the book), to help you select the appropriate patient status.

The Centers for Medicare & Medicaid Services (CMS) policy observes the CPT® new vs. established definition. CMS Transmittal R731CP, Change Request 4032 (www.cms.hhs.gov/transmittals/downloads/R731CP.pdf) further notes that only face-to-face services establish a patient: "An interpretation of a diagnostic test, reading an X-ray or EKG etc., *in the absence of an E/M service or other face-to-face* service with the patient does not affect the designation of a new patient."

According to this guidance, if Doctor X had seen a patient face-to-face within the past three years, that patient is established, even if Doctor X is seeing the patient for the first time in a new location.

New Specialty, New Patient

Note that the three-year rule applies only when physicians in the same practice are also of the same specialty. Two physicians in the same practice may see a patient for different reasons if the physicians are of different specialties recognized by CMS (for a list of Medicare-recognized physician specialties, go the CMS Web site: www.cms.hhs.gov/medicareprovidersupenroll/downloads/taxonomy.pdf).

For example, a general surgeon in a large multiple-specialty practice sees a patient in 2007 to remove skin lesions. In early 2009, the same patient sees an internist (who is a member of the same multispecialty practice as the surgeon who treated the patient previously) for a new condition. Because the surgeon and internist (who are of different specialties) saw the patient for unrelated problems, the internist may report the initial visit using the new patient codes (e.g., 99201-99205).

Note that the three-year rule applies only when physicians in the same practice are also of the same specialty. Two physicians in the same practice may see a patient for different reasons if the physicians are of different specialties recognized by CMS.

The AMA allows an exception for new physicians seeing for the first time a patient established to the practice. *CPT® Assistant*, November 2008, features the following question and answer:

"**Question:** *Can new physicians who come on board to a group practice with their own tax identification numbers charge a new evaluation and management code for patients they see?*

"**Answer:** According to CPT® guidelines, a new patient is one who has received no professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years. Also, if a physician is new to this group practice and had never seen or billed a patient previously though his tax ID number, this should be considered a new patient for the purposes of this physician billing for his evaluation and management service."

Under CMS rules as stated, however, just because a patient is new to a particular physician does not necessarily mean the patient may be billed as new. Check with your payer before claiming a patient seen face-to-face by a physician of the same specialty, in the same group, within the past three years as new.

Katherine Abel, CPC, CPC-I, CMRS, is the director of curriculum for the AAPC.

Janet Dunkerley, CPC, CPC-I, CMC

Senior Medical Consultant for Quadramed, Inc.

Coding Edge (CE): Tell us a little bit about your career.

Janet: After finishing a five-year enlistment in the U.S. Navy with a background in computer science, I worked as an administrative assistant for Dr. Joseph Rubin, chief of cardio-thoracic surgery, at the Medical College of Georgia. When an opening for a coder became available, he offered me the position. He believed that anyone with a computer background and a love for numbers would be a perfect fit. I don't think that's accurate for everyone; however, in this instance, he was correct. He encouraged me to become a certified coder and to learn everything I could about coding, billing, and insurance. I took to coding like a fish to water and I've been very happy with my career path. Since then, I've worked as a billing department manager, coding instructor, accounts receivable manager, director of physician's services, and medical consultant.

CE: What is your involvement level with your local AAPC chapter?

Janet: I am founder of the Columbia, S.C. local chapter, established in 1995, and have served as chapter president and secretary. I am the editor of the monthly publication *Capital Coders* newsletter, which is sent to our local chapter members. I teach a quarterly Certified Professional Coder (CPC®) review class to prepare members for the CPC® exam. I speak at our local chapter meetings and workshops. I mentor new CPC-As by placing them in offices for practical experience and teaching them successful billing department fundamentals. I am one of the original members of the American Academy of Professional Coders Chapter Association's (AAPCCA) board of directors, serving as board secretary from 2007-2009. In 2008, I was voted as our local chapter's Networker of the Year and was selected as a co-winner of the Region 3 Networker of the Year.

CE: What has been your biggest challenge as a coder?

Janet: Education. Stressing the importance of education and making sure coders - as well as physicians - have the most up-to-date tools they need for success is challenging. When we stop learning, we stop growing, and then we fall behind. My biggest challenge has been keeping ahead of the pack; and I find the best way do to that is through education. I keep up by attending seminars, using the most current coding and educational materials, and using networking skills to keep abreast of trends and changes in the industry.

CE: What do you advise other coders to do if they disagree with the way a physician has coded his chart? Do you approach the physician, or have a monthly meeting?

Janet: Yes, the physician should be aware of any discrepancies, but I advise coders to proceed with caution. In the past, I have held monthly educational meetings in a classroom setting with practitioners and had great results. The doctors share their tips with each other on documentation and on avoiding pitfalls. If you need to meet one-on-one, knowing your physician and communicating effectively is key. For example, if you know your doctor has no time to beat around the bush, take a direct approach. First, ask the physician when it would be a good time to talk. Make sure you know what you want to say in case the physician says, "Right now." Have your facts straight and back them up with book, chapter, and verse. Anticipate questions; prepare answers. Tone is important—you don't want to sound condescending or arrogant. Be professional. Present your reasoning and suggest future fixes. Ask for input. You may come out with a better understanding of their thought process. Always thank a physician for his or her time.

CE: If you could have any other job, what would it be?

Janet: I would be a romance writer. Actually, I am a romance writer, but I'd love to write full-time, out on a back porch in the mountains somewhere, away from all the hustle of city life, where you can hear the birds chirp and the wind blowing through the trees. Otherwise, I think I already have the perfect job.

CE: How do you spend your spare time?

Janet: I love to write and read. I love period romances, which may be why I'm hooked on Renaissance faires, knights in shining armor, and castle motif. I collect castles and chalices. My husband, Todd, and I love to travel and plan to go back to Germany for our 25th anniversary to tour castles. Neuschwanstein is one of our favorites. We love to dance and enjoy spending time with our grandchildren. I'm also really into Yogalates (yoga and Pilates) and daily meditation. CE

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CDC's Quick Action

Creates new code for H1N1 influenza virus

By G. John Verhovshek, MA, CPC

The CDC wanted to match WHO's efforts to track the disease. The closest existing ICD-9-CM code—488 *[Influenza due to identified avian influenza virus]*, which parallels ICD-10 code J09—was specific to avian flu. We needed a new code.

As reported in last month's "Coding News," new ICD-9-CM code 488.1 *Influenza due to identified novel H1N1 influenza virus* to describe the novel H1N1 virus—commonly known as "swine flu"—will go into effect Oct. 1 (*Coding Edge*, August 2009, page 10). Inclusion of this code in the October update required swift action by the Centers for Disease Control and Prevention (CDC) and the National Center for Health Statistics (NCHS), acting in concert with the World Health Organization (WHO)—the directing and coordinating authority for health within the United Nations system.

"Discussion among WHO's Family of International Classifications network and WHO regional offices began shortly after the influenza A novel H1N1 virus was identified in April, and continued for approximately two months," explains Donna Pickett, MPH, RHIA, medical systems administrator with the CDC. "WHO wanted to capture data about the virus, but because this was a new strain, there was no code in either ICD-9 or ICD-10 to identify it specifically.

"The CDC wanted to match WHO's efforts to track the disease. The closest existing ICD-9-CM code—488 [*Influenza due to identified avian influenza virus*], which parallels ICD-10 code J09—was specific to avian flu. We needed a new code.

"Since 2004, the ICD-9-CM classification has had the potential to be updated twice per year: April 1 and Oct. 1. To be included in the October update, a code normally would have to be presented at the ICD-9-CM Coordination and Maintenance Committee meeting the previous March. Because novel H1N1 swine flu wasn't identified until after the meeting, there was no way to create a code in time for the October 2009 update through the usual process.

"There was an immediate need. Rather than wait until April 2010, we fast-tracked a swine flu code. Category 488 has been expanded to include 488.0, for avian flu, and code 488.1, which is specific for novel H1N1 influenza. The new codes are effective Oct. 1."

Pickett notes that other codes have been similarly fast-tracked in the past. "We introduced new codes 480.31 *Pneumonia due to SARS-associated coronavirus* and V01.82 *Exposure to SARS-associated coronavirus* in response to SARS in 2003, and created new E codes to describe injury by terrorist attack shortly after the events of Sept. 11, 2001. In 1986, a similar approach was used to revise codes for HIV.

"Until code 488.1 *Influenza due to identified avian influenza virus* goes into effect Oct. 1, swine flu should be identified using an appropriate code from category 487 *Influenza*, according to the individual patient's manifestations," Pickett says. "For instance, for a patient with influenza and pneumonia, report 487.0 *Influenza; with pneumonia*."

As an interim measure, WHO has decided to continue to categorize swine flu to ICD-10 code J09, but Pickett expects a dedicated code will be created when the WHO-FIC meets this October. "We'll be sure that the final decision is reflected in the ICD-10-CM code set to be implemented here in the U.S. in 2013." CE

G. John Verhovshek, MA, CPC, is AAPC's director of clinical coding communications.

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